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ABSTRACT

This module, consisting of materials for use in conducting a consumer education mini-course, deals with health care and services for consumers. Covered in the individual lessons are the following topics: understanding what is and is not covered by Medicare, assessing the need for private health insurance, purchasing private health insurance, choosing a doctor, choosing a hospital, choosing a dentist, and getting a second opinion when facing surgery. Each lesson contains an outline of the major concepts to be covered in the lesson, suggested activities, a list of instructional materials included in the lesson, a list of pertinent references, test questions, an answer sheet, an information outline, and transparency masters. (MN)

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HEALTH CARE AND SERVICES FOR CONSUMERS

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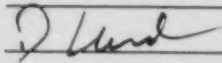
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HEALTH CARE AND SERVICES FOR CONSUMERS

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HEALTH CARE AND SERVICES FOR CONSUMERS

LESSON: What Medicare Covers

CONCEPTS:

1. Medicare provides two broad areas of coverage:
Hospital (Part A) and
Medical (Part B)
2. Your Medicare Health Insurance Card shows what coverage you have.
3. The combination of both hospital and medical insurance provides a broad comprehensive package of health insurance protection.

SUGGESTED ACTIVITIES:

1. Call or visit your nearest Social Security Administration Office for free quantities of:

A Brief Explanation of Medicare, SSA Publication No. 05-10043, January, 1983.

Your Medicare Handbook, SSA Publication No. 05-10050, January, 1983.

These publications may also be obtained free of charge from:

U. S. Department of Health and Human Services
Social Security Administration
Health Care Financing Administration
Baltimore, Maryland 21235

2. Make transparencies from masters provided.
3. Provide students with individual copies of each of these publications. Much of the information in this series is very technical. These publications take the place of information sheets with specific facts that can be referred to later.
4. Give a pre-test to assess the degree of students' knowledge in this area.
5. Use test questions to stimulate discussion and introduction to the lesson.

INSTRUCTIONAL MATERIALS:

1. A Brief Explanation of Medicare
2. Your Medicare Handbook
3. Transparency masters

TM-1: Medicare Has Two Parts:

TM-2: Hospital Insurance - Benefit Periods

TM-3: Hospital Insurance - When You're a Hospital Inpatient

TM-4: Hospital Insurance - Lifetime Reserve Days

TM-5: Hospital Insurance - Skilled Nursing Facility

TM-6: Hospital Insurance - Home Health Services

TM-7: Hospital Insurance - Hospice Care

TM-8: Medical Insurance - What is Covered

TM-9: Medical Insurance - What Medicare Pays

TM-10: Medical Insurance - When Your Doctor or Supplier
Accepts Assignment

TM-11: When Your Doctor Does Accept Assignment

TM-12: Medical Insurance - When Your Doctor or Supplier
Does Not Accept Assignment

TM-13: When Your Doctor Does Not Accept Assignment

4. Test
5. Answers to tests

LESSON REFERENCES:

1. A Brief Explanation of Medicare. U. S. Department of Health and Human Services, Social Security Administration, SSA Publication No. 05-10043, January, 1983.
2. Medicare and Private Health Insurance: A Training Text. U. S. Department of Health and Human Services, Health Care Financing Administration.
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HEALTH CARE AND SERVICES FOR CONSUMERS

LESSON: What Medicare Covers

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TM-5: Hospital Insurance - Skilled Nursing Facility

TM-6: Hospital Insurance - Home Health Services

TM-7: Hospital Insurance - Hospice Care

TM-8: Medical Insurance - What is Covered

TM-9: Medical Insurance - What Medicare Pays

TM-10: Medical Insurance - When Your Doctor or Supplier
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3. Your Medicare Handbook. U. S. Department of Health and Human Services, Social Security Administration, SSA Publication No. 05-10050, January, 1983.

TEST QUESTIONS

What Medicare Covers

Multiple Choice:

1. A "benefit period"
 - a. begins when you enter a qualified hospital
 - b. is limited to 2 per year
 - c. ends when you enter a qualified hospital
2. The inpatient hospital deductible
 - a. is charged only once each year
 - b. is charged only once each benefit period
 - c. is \$150.00 for each benefit period in 1983
3. Custodial care in a nursing facility
 - a. is care primarily needed to help in meeting personal care needs, such as eating, dressing, etc.
 - b. is paid for by Medicare
 - c. is care considered "medically necessary".
4. For the first 20 days in a skilled nursing facility, Medicare
 - a. pays for all covered services
 - b. pays for all covered services except for \$38.00 a day
 - c. pays nothing
5. Medical Insurance
 - a. is provided under Part A of Medicare
 - b. is automatically part of your coverage if you are eligible for Medicare
 - c. does not cover diagnostic testing, X-rays or outpatient hospital services
6. Medical Insurance
 - a. pays 100% of the "reasonable charges"
 - b. has an annual \$75.00 deductible
 - c. has a \$75.00 deductible on every doctor bill

TRUE-FALSE

- T F 1. Medicare only provides inpatient care in a hospital.
- T F 2. Doctors' services are covered under Part B--Medical Insurance.
- T F 3. Medical insurance coverage is elective and is paid for monthly.

- T F 4. If your hospital stay lasts for 90 days, you will pay a co-payment of \$76.00 per day for the 61st through the 90th day.
- T F 5. If you stay out of the hospital or skilled nursing facility for 60 days in a row, then a new benefit period starts the next time you enter a hospital.
- T F 6. "Lifetime reserve days" when used are not replaced when a new benefit period begins.
- T F 7. You do not pay any of the cost of the "lifetime reserve days" when they are used.
- T F 8. Most nursing homes are not skilled nursing facilities and do not qualify for Medicare.
- T F 9. When a doctor or supplier accepts "assignment" he agrees to accept Medicare's "reasonable charge" as the total charge for the services covered by the assignment.
- T F 10. It is easy to obtain private health insurance that will pay the amounts above what Medicare accepts as "reasonable".
- T F 11. Medicare pays the full reasonable costs of home health visits.
- T F 12. There is no deductible or co-payments for home health services furnished by a home health agency participating in Medicare.
- T F 13. Homemaker or other services that assist you in dressing, bathing, eating, housekeeping, and shopping are covered by Medicare.

What Medicare Covers

Answer Sheet

Multiple Choice

1. a
2. b
3. a
4. a
5. a
6. b

True-False

1. F
2. T
3. T
4. T
5. T
6. T
7. F
8. T
9. T
10. F
11. T
12. T
13. F

HEALTH CARE AND SERVICES FOR CONSUMERS

WHAT MEDICARE COVERS

INFORMATION OUTLINE

I. Basic Provisions (Use TM-1)

Medicare is two separate programs:

Part A - Covers Hospital Insurance

Part B - Covers Medical Insurance

Hospital insurance covers inpatient care in four areas:

In a hospital

Inpatient care in a skilled nursing facility

Home health care services in your home after a hospital stay

Hospice Care - Beginning in November, 1983

Medical insurance covers

Doctor's services

Outpatient hospital services

Home health services

Other health care services, such as X-rays and laboratory services, ambulance services, physical therapy, and rental or purchase of durable medical equipment.

You can tell what Medicare coverage you have and when it began by examining your Health Insurance Card. If you have only one part of Medicare, it will probably be for hospital coverage, (Part A). If you do not have hospital insurance (Part A), it can be obtained at a cost of \$132.00 per month (July 1, 1983-June 30, 1984). If you do not have Medical Insurance, (Part B), it can be obtained at a cost of \$13.50 per month (July 1, 1983-June 30, 1984) provided you have hospital insurance also. You can contact any Social Security Office for information on obtaining this coverage.

II. Hospital Insurance - Benefit Periods (Use TM-2)

The three benefits under Medicare's hospital insurance program - inpatient hospital care, skilled nursing facility care and home health care - are paid on the basis of benefit periods.

A benefit period begins when you enter a qualified hospital and ends when you have been out of a hospital or skilled nursing facility for 60 consecutive days. Then a new benefit period can begin the next time you enter a hospital. There is no limit to the number of benefit periods you can have, but after one benefit period begins, a new one cannot start until you have not been an inpatient in a hospital or skilled nursing facility for 60 days in a row.

Within each benefit period, Medicare hospital insurance will cover up to 90 days of inpatient hospital care, up to 100 days of inpatient skilled nursing facility care and unlimited home health visits. Regardless of how many days or visits you use in one benefit period, the full amounts are restored each time a new benefit period begins.

III. Hospital Insurance - When You Are A Hospital Inpatient (Use TM-3)

In each benefit period, you are entitled to as many as 90 days of inpatient hospital care in any hospital that participates in Medicare. Almost all hospitals in the U. S. do participate.

For the first 60 days of inpatient hospital care in a benefit period, you are responsible for the first \$304 (1983 amount; this figure changes annually) of expenses. This is called the inpatient hospital deductible and is charged only once in each benefit period. Except for this deductible, and the charges for noncovered services, such as telephone, television or a private room that is not medically necessary, Medicare hospital insurance pays for all the covered services you receive during your first 60 days of inpatient hospital care in each benefit period.

For the 61st through the 90th day of inpatient hospital care in each benefit period, Medicare hospital insurance will pay for all covered services except for \$76 (1983 amount; this figure will change annually) a day.

If you ever need to use more than 90 days in a benefit period, you can utilize "lifetime reserve" days.

The 90 days of inpatient hospital care in each benefit period do not have to be consecutive. For example, if you are in a hospital for 10 days and are then discharged, you would have 80 days that you can still use in that benefit period. If you stay out of a hospital or skilled nursing facility for 60 days in a row, or course, then a new benefit period starts the next time you enter a hospital and your full 90 days are reinstated. You must pay a new deductible for each new benefit period.

(The deductible and co-payment amounts shown for inpatient hospital services and skilled nursing facility services are subject to change at the beginning of each calendar year. The amounts shown are for calendar year 1983).

IV. Hospital Insurance - Lifetime Reserve Days (Use TM-4)

The average inpatient hospital stay by Medicare beneficiaries is 11 days. For the great majority of beneficiaries, the 90 days of inpatient hospital care they are entitled to in each benefit period will cover all the inpatient hospital care they will ever need in their lifetime. Even if, on occasion, they have an above average hospital stay of, for example, 40 or 50 days, as soon as they are out of a hospital or skilled nursing facility for 60 days in a row, a new benefit period can begin and the original

90 days of inpatient hospital care can start over again. So, for most beneficiaries, Medicare hospital insurance is almost total protection against covered inpatient hospital care costs.

But, now and then, a beneficiary may need more than 90 days of inpatient hospital care in a benefit period. For that reason, Medicare hospital insurance provides 60 additional inpatient hospital days that can be drawn from whenever more than 90 days is required in a benefit period. These 60 days are called "lifetime reserve" days. This means that you can have as many as 150 covered days of inpatient hospital care in a benefit period. But once you use them, lifetime reserve days are not replaced when a new benefit period begins.

For each "lifetime reserve" day used, Medicare pays for all covered services except \$152 (for 1983; this figure will change annually) a day.

V. Hospital Insurance - When You Are in a Skilled Nursing Facility
(Use TM-5).

Sometimes, people who are receiving care as hospital inpatients reach the point in their treatment when they no longer need the intensive--and expensive--care furnished by the hospital, but are not well enough to go home. They still need skilled nursing care and rehabilitation services to help them in their recovery.

Medicare hospital insurance provides for as many as 100 days of posthospital care in a Medicare certified skilled nursing facility for beneficiaries who need this additional level of care. For the first 20 days of care in a skilled nursing facility in each benefit period, Medicare hospital insurance pays for all

covered services. For the 21st through the 100th day, Medicare hospital insurance pays for all covered services except for \$38.00 a day (for 1983; this figure will change annually).

Most "nursing homes," as that term is generally understood, are not skilled nursing facilities. Medicare only covers care in a skilled nursing facility and only when the care being furnished is medically necessary for the further treatment of a condition that was treated during the patient's hospital stay. Medicare does not cover care which mainly is custodial, that is, care which is primarily needed to help in meeting personal care needs, such as eating, dressing, getting in and out of bed and taking medication.

VI. Hospital Insurance - When You Receive Home Health Services
(Use TM-6).

Sometimes, after a hospital stay or after receiving care in a skilled nursing facility, people no longer need round-the-clock services in an institutional setting, but still need part-time convalescent care that can be provided in their own homes through periodic visits by skilled nurses, or physical or speech therapists.

To help meet this need, Medicare hospital insurance provides unlimited health visits for each benefit period, when skilled nursing and other therapy services are furnished by a home health agency participating in Medicare. Medicare pays the full reasonable costs for these visits. Under hospital insurance you have no deductible or co-payment for home health services. The services must be for further treatment of a condition for which you received care in your previous hospital or skilled nursing facility stay

and must be furnished under a medical treatment plan supervised by your doctor. Medicare does not cover homemaker or other services which are primarily offered to assist you, such as help with dressing, bathing, eating, housekeeping and shopping.

VII. Hospice Care - A New Care Benefit (Use TM-7).

Starting November 1, 1983, hospital insurance will help pay for hospital care for terminally ill beneficiaries with a life expectancy of 6 months or less. These beneficiaries can choose to receive hospice care instead of other Medicare benefits, except services of the attending doctor. Covered hospice care will include nursing care, therapies, medical social services, homemaker-home health aide services, short-term inpatient care, outpatient drugs for pain relief, and respite care. Special benefit periods, daily co-insurance amounts, and coverage requirements will apply to the new hospice care benefit.

VIII. Medical Insurance - Covered Services (Use TM-8).

Medical insurance covers doctor's services regardless of where they are furnished--in the doctor's office, a clinic, a hospital or skilled nursing facility or in your home.

It covers outpatient hospital services, either in the hospital outpatient department or in the emergency room, both for diagnosis and for treatment services.

It covers services by independent clinical laboratories for diagnostic testing and covers unlimited numbers of home health visits.

Medical insurance also covers diagnostic X-ray and radiation therapy services, physical therapy services in a doctor's office,

a clinic and, to a limited degree, in a physical therapist's office or in your home. It covers prosthetic devices, purchase or rental of durable medical equipment for use in your home, certain ambulance services and a number of other medical supplies and equipment.

The combination of medical insurance and hospital insurance provides a broad and comprehensive package of health insurance protection.

IX. Medical Insurance - What Medicare Pays (Use TM-9).

Medical insurance pays 80 percent of the "reasonable charges" for covered services after an annual \$75 deductible is met. The \$75 annual deductible must represent covered services and is based on "reasonable charges" rather than actual bills.

"Reasonable charges" are updated every July 1 to try to keep pace with changes in medical care prices. Because this update is based on price information collected during the preceding year, and because price changes during the current period of high inflation have been more frequent than in the past, the "reasonable charges" on which medical insurance benefits are based are often less than the charges doctors and suppliers will bill you. As a result, 80 percent of "reasonable charges" will often be less than 80 percent of your bill from a doctor or supplier.

As we will note later, this difference between the actual charge to you and the "reasonable charge" on which Medicare benefits are based is one of the major gaps in Medicare. Very few private insurance policies exist which help you to meet this additional cost.

Where your doctor or supplier takes an "assignment," discussed in the next section, you can avoid this additional expense.

X. Medical Insurance - Assignment (Use TM-10 and TM-11).

The Medicare program has no legal authority to limit the amounts doctors and suppliers may charge Medicare beneficiaries. But the law authorizes a voluntary arrangement called "assignment." Under this arrangement, a doctor or supplier can agree to accept the Medicare payment directly from the program, but as a condition of such direct payment, must also agree to accept Medicare's "reasonable charge" as the total charge for the services covered by the assignment.

If your doctor or supplier accepts assignment, this means that he or she can only charge you for any of the \$75 annual deductible not yet met, for 20 percent of the remaining "reasonable charges" and, of course, for any services not covered by the program. In an assignment case, you cannot be charged for any difference between the "reasonable charge" and the actual charge the doctor or supplier would otherwise have billed to you. (Use TM-11 to illustrate the possible cost if a doctor does accept assignment.)

Assignment is a case-by-case choice. Some doctors and suppliers always take assignment. Some never accept assignment. Most will accept assignment on some claims, but not on others. It is a voluntary choice both for you and the doctor or supplier. Because it will usually be to your financial advantage, you should always ask.

XI. Medical Insurance - Nonassignment (Use TM-12 and TM-13).

When the doctor or supplier does not agree to an assignment, you must file the medical insurance claim and the Medicare payment is sent to you.

The medical insurance payment will be 80 percent of the "reasonable charge" for the covered services you received after your \$75 annual deductible is met. You are responsible for the entire amount the doctor or supplier has billed you.

If the difference between the "reasonable charge" and the actual charge you are billed is large enough to cause a hardship, you should consider discussing the difference with the doctor or supplier. Some may be willing to adjust their charge in your favor or, at least, work out a payment arrangement over a longer period than usual.

TM-13 illustrates the possible additional cost to you if your doctor charges more than Medicare has accepted as "reasonable" and your doctor does not accept assignment.

(Note: Many private health insurance policies that advertise that they fill the Medicare "gap" will not pay more than the "reasonable charge" set by Medicare. Thus, private supplemental policies may only pay the 20 percent of "reasonable charges".)

What Medicare Covers

MEDICARE HAS TWO PARTS:

- **Hospital Insurance (Part A)**

Inpatient Hospital Care

Post-Hospital Skilled Nursing Facility Care

Post-Hospital Home Health Care

Hospice Care

(Available November 1, 1983)

- **Medical Insurance (Part B)**

Doctors' Services

Outpatient Hospital Services

Home Health Care
(without a hospital stay)

Other Health Care Services

This shows whether you have hospital insurance only, medical insurance only, or both



Health Insurance	
SOCIAL SECURITY ACT	
NAME OF BENEFICIARY	
CLAIM NUMBER	SEX
IS ENTITLED TO	EFFECTIVE DATE
Hospital Insurance	1-1-78
Medical Insured	1-1-78
SIGN HERE 	

TM-1

What Medicare Covers

HOSPITAL INSURANCE

(Part A)

Benefit Periods

- *Begin* when you enter a qualified hospital.
- *End* when you're out of a hospital or skilled nursing facility for 60 days in a row.
- No limit to the *number* of benefit periods.

What Medicare Covers

HOSPITAL INSURANCE (Part A)

When You're A Hospital Inpatient

- 90 Days per benefit period

First 60 days—You pay \$304, Medicare pays the rest*

61st thru 90th day—You pay \$75, a day, Medicare pays the rest*

- **Covered Services:** semi-private room, general nursing care, drugs, lab services, x-rays, operating and recovery room special care units, anesthesia, rehab services

*(1983 Amounts)

What Medicare Covers

HOSPITAL INSURANCE (Part A)

Lifetime Reserve Days

- 60 hospital days that can be used if more than 90 days of inpatient hospital care are needed in a benefit period.
- Cost you \$152 each to use (1983 amount)
- Used "lifetime reserve" days *not* replaced when new benefit period begins.

What Medicare Covers

HOSPITAL INSURANCE (Part A)

When You're In A Skilled Nursing Facility

- 100 days per benefit period

First 20 days—Medicare pays all

21st thru 100th day—You pay \$38.00 per day.

Medicare pays the rest (1983 amount)

- Covered services—semi-private room, general nursing care, drugs, rehab services, medical supplies and equipment

NOTE: Most nursing homes are NOT skilled nursing facilities.

What Medicare Covers

HOSPITAL INSURANCE

When You Receive Home Health Services

- **Unlimited Visits Per Benefit Period – Medicare Pays All**
- **Covered Services.** Part-time skilled nursing care, physical therapy, speech therapy.

If you need any of the above services: Also covers part-time home health aide services, occupational therapy, medical social services, medical supplies and equipment.

What Medicare Covers

HOSPITAL INSURANCE (Part A)

Hospice Care

- Begins November 1, 1983
- For terminally ill beneficiaries with a life expectancy of 6 months or less
- Includes: nursing care
therapies
medical social services
homemaker-home health aide services
short-term inpatient care
outpatient drugs for pain relief
- Special benefit periods, daily co-insurance amounts and coverage requirements will apply

What Medicare Covers

MEDICAL INSURANCE

What Is Covered

- Doctors' Services
- Outpatient Hospital Services
- Laboratory Services
- X-Ray and Radiation Therapy Services
- **Unlimited Home Health Visits**
- Physical Therapy and Speech Pathology Services
- Durable Medical Equipment
- Limited Ambulance Services
- Prosthetic Devices and Other Medical Supplies and Equipment

What Medicare Covers

MEDICAL INSURANCE

What Medicare Pays

- 80 percent of “reasonable charges” after **\$75** annual deductible is met.

“*Reasonable charges*”—updated every July 1, based on actual charges by doctors and suppliers *in your area* during the *preceding* calendar year.

Reasonable Charges—often *less* than what your doctor or supplier currently charges because of time “lag” and inflation.

What Medicare Covers

MEDICAL INSURANCE

When Your Doctor or Supplier Accepts Assignment

- Medicare payment is sent directly to doctor or supplier
- You are responsible for any of the \$75 annual deductible not yet met
- 20 percent of the "reasonable charge"
- Any items or services *not* covered by Medicare
- Your Total Payment to the Doctor or Supplier Cannot Exceed the "Reasonable Charge" set by Medicare.

WHEN YOUR DOCTOR DOES ACCEPT ASSIGNMENT

"REASONABLE"-MEDICARE \$1200.00

DOCTOR'S CHARGE \$1200.00

NO DIFFERENCE \$ 0.00

WHAT YOU WILL BE EXPECTED TO PAY:

\$75.00 DEDUCTIBLE \$ 75.00

20% OF "REASONABLE" CHARGE \$ 225.00

LESS THE DEDUCTIBLE

\$ 300.00

TM-11

What Medicare Covers

MEDICAL INSURANCE

(Part B)

When Your Doctor or Supplier Does Not Accept Assignment

- Medicare payment sent directly to you.
- You Are Responsible For The Entire Bill
- Your Medicare payment is 80 percent of the "reasonable charge" for covered services after the \$75 annual deductible is met.

WHEN YOUR DOCTOR DOES NOT ACCEPT ASSIGNMENT

DOCTOR'S CHARGE	\$1500.00
"REASONABLE"-MEDICARE	\$ <u>1200.00</u>
DIFFERENCE YOU PAY	\$ 300.00

WHAT YOU WILL BE EXPECTED TO PAY:

DIFFERENCE YOU PAY	\$ 300.00
20% OF \$1125.00	\$ 225.00
\$75.00 DEDUCTIBLE	\$ <u>75.00</u>
	\$ 600.00

HEALTH CARE AND SERVICES FOR CONSUMERS

LESSON: What Medicare Does Not Cover

CONCEPTS:

1. There are three major categories of health care expenses not covered by Medicare.
2. Knowledge of these gaps is necessary in making a decision about whether or not additional private insurance is needed to supplement Medicare.
3. Persons eligible for Medicaid have no need for additional private insurance to provide additional coverage and should not purchase supplemental private health insurance.

SUGGESTED ACTIVITIES:

1. Supply copies of A Brief Explanation of Medicare and Your Medicare Handbook to those who do not have them. (See previous lesson on What Medicare Covers)
2. Provide students with a copy of HO-1: What Medicare Does Not Cover. This is a summary of the gaps in the Medicare Program.
3. Ask participants to share their experiences with Medicare coverage--how much of the medical expense it paid and how much their out-of-pocket expenses were.
4. Use test questions either as pre or post test in assessing students' understanding of Medicare coverage.
5. Provide students with copies of AS-1: Do I Need Health Insurance to Supplement Medicare?
6. Ask students to evaluate supplemental health insurance policies they have, using AS-1.

INSTRUCTIONAL MATERIALS:

1. HO-1: What Medicare Does Not Cover
2. AS-1: Do I Need Health Insurance to Supplement Medicare?

3. Transparency Masters

- TM-1: Medicare Does Not Cover: The Three Gaps
- TM-2: Medicare Does Not Cover: Deductibles and Co-Payments
- TM-3: Medicare Does Not Cover: Non-covered Items and Services
- TM-4: Medicare Does Not Pay For: Charges that Exceed "Reasonable Charges".

4. A Brief Explanation of Medicare

5. Your Medicare Handbook

LESSON REFERENCES:

1. A Brief Explanation of Medicare. U. S. Department of Health and Human Services, Social Security Administration, SSA Publication No. 05-10043, January, 1983.
2. Medicare and Private Health Insurance: A Training Text. U. S. Department of Health and Human Services, Health Care Financing Administration.
3. Your Medicare Handbook. U. S. Department of Health and Human Services, Social Security Administration, SSA Publication No. 05-10050, January, 1983.

TEST QUESTIONS

What Medicare Does Not Cover

Multiple Choice:

1. A major medical expense not paid by Medicare is
 - a. diagnostic and clinical tests
 - b. home health visits
 - c. deductibles and co-payments
2. On your first admission to a hospital in each benefit period you will pay (1983 amount)
 - a. \$152.00
 - b. \$38.00
 - c. \$304.00
3. For the 61st through the 90th day of inpatient hospital care in each benefit period, you will pay (1983 amount)
 - a. \$76.00 a day
 - b. \$152.00 a day
 - c. \$38.00 a day
4. For each "lifetime reserve" day you use, you will pay (1983 amount)
 - a. \$304.00
 - b. \$152.00
 - c. \$38.00 a day
5. The annual deductible you pay for covered medical expenses is
 - a. \$304.00
 - b. \$75.00
 - c. \$150.00

TRUE-FALSE

- T F 1. Medicare pays for eyeglasses and hearing aids.
- T F 2. Dental care is not covered by Medicare.
- T F 3. Private rooms and private duty nurses are not usually provided by Medicare.
- T F 4. Drugs and medicines you purchase yourself are paid for by Medicare.
- T F 5. Most private health insurance policies will pay for the items that Medicare does not cover.

What Medicare Does Not Cover

Answer Sheet

Multiple Choice

1. c
2. c
3. a
4. b
5. b

True-False

1. F
2. T
3. T
4. F
5. F

HEALTH CARE AND SERVICES FOR CONSUMERS

WHAT MEDICARE DOES NOT COVER

INFORMATION OUTLINE

I. The Three Gaps in Medicare (Use TM-1).

There are three major categories of health care expenses not covered by Medicare that represent gaps. They are:

1. The Medicare deductibles and co-payments for the services Medicare covers.
2. The Medical items and services that Medicare does not cover at all.
3. In non-assignment cases, the difference between the "reasonable charge" and the actual charge for covered services by doctors and suppliers under the medical insurance program.

Your choice of a private health insurance policy, if you decide you want and need added protection, should be based on a careful consideration of how well it fills the gaps in Medicare that you feel you should be insured against. The different types of private insurance you can buy offer different needs and preferences. The more you know about what Medicare covers and what it does not cover, and how these different kinds of private health insurance relate to gaps in Medicare, the better choice you will make for your own individual situation.

II. Deductibles and Co-Payments (Use TM-2).

The deductibles and co-payments under Medicare are specific money amounts for covered services that the program does not pay, or in the case of blood, a specific initial quantity of blood for which you can be charged before Medicare assumes all or part of the additional costs.

In the hospital insurance program, there are basically five fixed amounts which the program does not pay even though the services are otherwise covered. These are:

1. The \$304 inpatient hospital deductible that you pay on your first admission to a hospital in each benefit period.
2. The \$76 a day for the 61st through the 90th day of inpatient hospital care in each benefit period.
3. The \$152 a day for each "lifetime reserve" day you use for inpatient hospital care after 90 days of such care in a benefit period.
4. The \$38 a day for the 21st through the 100th day in each benefit period for care in a skilled nursing facility.
5. The first three pints of blood you use in each benefit period in connection with covered hospital insurance services.

In the medical insurance program there are three such fixed amounts. These are:

1. The first \$75 of covered medical expenses in each calendar year--the annual medical insurance deductible.
2. Twenty percent of the "reasonable charges" for covered services.
3. The first three pints of blood you use in a calendar year in connection with covered medical insurance services.

The money amounts in the medical insurance program are established by law and can only be changed if the Medicare law is amended. Money amounts in the hospital insurance program are subject to change at the beginning of each calendar year.

III. Non-Covered Items and Services (Use TM-3).

The gap area represented by items and services not covered at all under Medicare is the area that involves the largest

out-of-pocket costs by Medicare beneficiaries. It is also an area in which VERY FEW PRIVATE HEALTH INSURANCE POLICIES OFFER SIGNIFICANT ADDITIONAL PROTECTION.

The major services not covered by Medicare hospital insurance are:

1. Services after 150 days of inpatient hospital care in a benefit period (after 90 days if you have used all your "lifetime reserve" days).
2. Services after 100 days of inpatient skilled nursing facility care in a benefit period.
3. Nursing home care in other than a skilled nursing facility.
4. A private room in a hospital or skilled nursing facility, or private duty nursing in either facility.

The major services not covered by Medicare medical insurance are:

1. Drugs and Medicines you buy yourself.
2. Eyeglasses (except prosthetic lenses after cataract surgery) and routine eye examination.
3. Hearing aids and routine hearing loss examinations.
4. Dental care.

Neither hospital insurance nor medical insurance covers services which are not medically necessary, nor services in a foreign country (with some exceptions for Canada and Mexico).

IV. Charges that Exceed "Reasonable Charges" (Use TM-4).

As we discussed earlier, the "reasonable charge" on which Medicare bases its payments under the medical insurance program is often less than the amount billed to you by a doctor or supplier. In fact, in 1978 over 70 percent of all allowed claims under the medical insurance program were reduced because

the billed amount exceed the Medicare "reasonable charge."

Of the total money amount reduced approximately one-half was for unassigned claims. As you remember, when a claim is unassigned, the beneficiary, in addition to paying the deductible and co-payment, is responsible for paying the difference between the actual charge and the "reasonable charge." This large money amount for which beneficiaries are responsible in unassigned medical insurance claims is a major gap. (Refer back to TM-10, TM-11, TM-12, and TM-13).

Very few private health insurance policies exist which cover these charges. Whenever possible, therefore, you should try to secure doctor and supplier services on an assignment basis.

WHAT MEDICARE DOES NOT COVER

There are three major categories of health care expenses not covered by Medicare that represent "gaps" in the coverage provided. The major "gaps" are:

I. The Deductibles and Co-payments in the Hospital and Medical Insurance

A. Hospital Insurance Deductibles and Co-payments

1. The \$304 inpatient hospital deductible that you pay on your first admission to a hospital in each benefit period.
2. The \$76 a day for the 61st through the 90th day of inpatient hospital care in each benefit period.
3. The \$152 a day for each "lifetime reserve" day you use for inpatient hospital care after 90 days of such care in a benefit period.
4. The \$38 a day for the 21st through the 100th day in each benefit period for care in a skilled nursing facility.
5. The first 3 pints of blood you use in each benefit period in connection with covered hospital insurance services.

B. Medical Insurance Deductibles and Co-payments

1. The first \$75 of covered medical expenses in each calendar year--the annual medical insurance deductible.
2. 20 percent of the "reasonable charges" for covered services.
3. The first three pints of blood you use in a calendar year in connection with covered medical insurance services.

II. Charges that Exceed "Reasonable Charges"

Because the "reasonable" charge is often less than the amount billed to you, you are responsible for paying the difference between the actual charge and the "reasonable" charge.

NOTE: Very few private companies exist which cover these charges when you purchase private insurance to supplement your Medicare coverage.

III. Non-covered Items and Services

A. Not Covered by Hospital Insurance

1. Services after 150 days of inpatient hospital care in a benefit period (after 90 days if you have used all your "lifetime reserve" days).
2. Services after 100 days of inpatient skilled nursing facility care in a benefit period.
3. Nursing home care in other than a skilled nursing facility.
4. A private room in a hospital or skilled nursing facility, or private duty nursing in either facility.

B. Not Covered by Medical Insurance

1. Drugs and medicines you buy yourself.
2. Eyeglasses (except prosthetic lenses after cataract surgery) and routine eye examination.
3. Hearing aids and routine hearing loss examinations.
4. Dental care.

Neither hospital insurance nor medical insurance covers services which are not medically necessary, nor services in a foreign country (with some exceptions for Canada and Mexico).

Do I Need Health Insurance to Supplement Medicare?

- If you are eligible for Medicaid, do not purchase private health insurance. The combination of Medicare and Medicaid pays almost all essential medical costs.
- Private health insurance can help pay some, but not all the expenses that Medicare doesn't cover.
- Because private health insurance will not provide for all the expenses that Medicare doesn't, be sure to consider:
 - The coverage
 - The cost
 - The risk

The following evaluation forms will help you do this.

EVALUATION FORM FOR
MEDICARE SUPPLEMENT POLICIES

NOT COVERED BY MEDICARE (1983 figures; subject to change in later years)	COVERED BY PROPOSED POLICY?		WHAT DOES PROPOSED POLICY	
	YES	NO	PAY?	COST?
\$304 for the first 60 days of inpatient hospital services in a benefit period (the inpatient hospital deductible)				
\$76 a day for the 61st to 90th day of inpatient hospital services in a benefit period				
\$152 a day for inpatient hospital services for each "lifetime reserve" day used (can be used up to a total of 60 days in your lifetime, whenever you need more than 90 days in a benefit period)				
Over 150 days of inpatient hospital services in a benefit period (over 90 days if you have used all your "lifetime reserve" days)				
\$38 a day for the 21st to 100th day in a benefit period for inpatient services in a skilled nursing facility				
Over 100 days of inpatient skilled nursing facility care in a benefit period				
Nursing home care in other than a skilled nursing facility				
Private room in a hospital or skilled nursing facility (except when medically necessary)				
Private duty nurses in a hospital or skilled nursing facility				
The first 3 pints of blood under either Medicare hospital or medical insurance				
The first \$75 of doctor bills and other medical services and supplies under Medicare medical insurance (the medical insurance annual deductible)				

EVALUATION FORM FOR
MEDICARE SUPPLEMENT POLICIES (CONT.)

NOT COVERED BY MEDICARE (1983 figures; subject to change in later years)	COVERED BY PROPOSED POLICY?		WHAT DOES PROPOSED POLICY	
	YES	NO	PAY?	COST?
After the first \$75 20% of "reasonable charges" for doctor bills and other bills for covered medical services and supplies under Medicare medical insurance				
Charges above the Medicare "rea- sonable charge" in non-assignment cases				
Drugs and medicines you buy yourself				
Eyeglasses (except after cataract surgery)				
Hearing aids				
Dental care				
Medical care outside the U. S.				

Are there any additional benefits the proposed policy pays? YES ___ NO ___

If yes, describe. _____

a. Is there a pre-existing condition exclusion? YES ___ NO ___

If yes, what conditions are excluded and for how long? _____

b. Is there a waiting period before policy pays benefits? YES ___ NO ___

If yes, when does the policy begin paying benefits? _____

c. What is the cost? _____

d. What is the risk? (What are your chances of needing coverage
not provided by Medicare?) _____

EVALUATION FORM FOR
HOSPITAL INDEMNITY POLICIES

- a. What is the daily payment rate? \$_____ per day
- b. On what day of a hospital stay do payments begin? _____
- c. What is the maximum number of days the policy will pay? _____
- d. Is there a maximum payment provision? If yes, what is the maximum amount? _____
- e. Are there any excluded illnesses? If yes, describe.

- f. Are there any benefits in addition to the daily payment rate? If yes, describe.

- g. What is the cost? _____
- h. What is the risk? (Why do I need a cash payment or what would be the result if I didn't have a cash payment?)

EVALUATION FORM FOR
NURSING HOME POLICIES

- a. Does the policy cover care in facilities other than skilled nursing facilities? YES NO

If yes, what other kinds of nursing homes?

Are these kinds of nursing homes available?

- b. Does the policy cover your stay in a skilled nursing facility or other nursing home when the care you need is primarily custodial care, that is, mainly personal care, such as help in feeding, dressing, getting in and out of bed, and taking medicine? YES NO

If yes, under what conditions and for how long will the policy pay for such care? Is this care available?

- c. Are there any excluded illnesses? If yes, describe.

- d. What is the cost?

- e. How great is my risk? (What are my chances for needing this kind of care? How could it be provided if I did not have this insurance?)

Medicare Does Not Cover:

THE THREE GAPS

- (1) Medicare deductibles and co-payments.
- (2) Non-covered items and services.
- (3) Charges exceeding "reasonable charges."

Medicare Does Not Cover:

DEDUCTIBLES AND CO-PAYMENTS

(1983 Amounts)

Hospital Insurance

- \$304 for the first 60 days of inpatient hospital services in a benefit period (the inpatient hospital deductible).
- \$76 a day for the 61st thru 90th day of inpatient hospital services in a benefit period.
- \$152 a day for each "lifetime reserve" day used.
- \$38.00 a day for the 21st thru 100th day in a benefit period for inpatient care in a skilled nursing facility.
- The first 3 pints of blood in a benefit period.

Medical Insurance

- The first \$75 each year of "reasonable charges" for covered services (the annual medical insurance deductible).
- 20 percent of the "reasonable charges" for all covered services above the deductible.
- The first 3 pints of blood in a calendar year.

MEDICARE DOES NOT COVER

NON-COVERED ITEMS AND SERVICES

HOSPITAL INSURANCE

- MORE THAN 150 DAYS OF INPATIENT HOSPITAL CARE IN A BENEFIT PERIOD (OVER 90 DAYS IF YOU HAVE USED ALL YOUR "LIFETIME RESERVE" DAYS).
- MORE THAN 100 DAYS OF INPATIENT SKILLED NURSING FACILITY CARE IN A BENEFIT PERIOD.
- NURSING HOME CARE IN OTHER THAN A SKILLED NURSING FACILITY.
- PRIVATE DUTY NURSING.
- PRIVATE ROOM (UNLESS MEDICALLY NECESSARY).

- CARE OUTSIDE THE UNITED STATES.
- SERVICES AND SUPPLIES THAT ARE NOT MEDICALLY NECESSARY.

MEDICAL INSURANCE

- DRUGS AND MEDICINES YOU BUY YOURSELF.
- EYEGLASSES (EXCEPT AFTER CATARACT SURGERY).
- HEARING AIDS.
- DENTAL CARE.

Medicare Does Not Pay For:

CHARGES THAT EXCEED 'REASONABLE CHARGES'

- Over *70 percent* of all allowed Medicare claims in the medical insurance program in 1978 were *reduced* because the billed amount exceeded the "reasonable charge."
- The total amount reduced was almost \$2 *billion*.
- Of this, almost half was for unassigned claims—a major out-of-pocket expense for the elderly.
- Few private insurance policies cover these charges.

HEALTH CARE AND SERVICES FOR CONSUMERS

LESSON: Do You Need Private Health Insurance to Supplement Medicare?

CONCEPTS:

1. The answer to this question is an individual decision that only you can make.
2. Private health insurance, if it is carefully chosen, and if you can afford the additional expense, can help fill some of the gaps.
3. Many private insurers claim that you will be "fully" protected by buying private insurance. NO private insurance plan provides full protection.
4. Medicaid recipients should not buy private health insurance.

SUGGESTED ACTIVITIES:

1. Review the costs that Medicare will not cover under Part A and Part B. (See HO-1)
2. Review AS-1, using overhead transparencies of the evaluation sheets to help students understand what they need coverage for, and also the fact that most of this coverage may not be obtainable in private health insurance either.
3. Use examples of some health insurance literature sent through the mail and other sources to senior citizens. Point out what coverage is provided relative to the gaps left by Medicare.
4. Provide each participant with a copy of Guide to Health Insurance for People with Medicare. These are obtainable in quantities, free of charge, from your nearest Social Security Office.
5. Test questions can be used as a pre or post test of students' understanding.

INSTRUCTIONAL MATERIALS:

1. Guide to Health Insurance for People with Medicare, HCFA-02110, Department of Health and Human Services/Health Care Financing Administration, January, 1981.
2. AS-1: Do I Need Health Insurance to Supplement Medicare?
3. Transparency Masters
 - TM-1: Two Important Facts
 - TM-2: Amounts Not Paid by Medicare
 - TM-3: Basic Types of Private Health Insurance
 - TM-4: Continuation or Conversion of Pre-65 Coverage
 - TM-5: Medicare Supplement Policies
 - TM-6: Co-Insurance
 - TM-7: Catastrophic or Major Medical Expense
 - TM-8: Deductible
 - TM-9: Health Maintenance Organizations (HMOs)
 - TM-10: Limited Coverage - Hospital Indemnity Policies
 - TM-11: Limited Coverage - Nursing Home Coverage Policies
 - TM-12: Extended Care Facility
 - TM-13: Rest Care or Custodial Care
 - TM-14: Limited Coverage - Specified Disease Policies
 - TM-15: Sample Advertisement for Private Insurance
 - TM-16: Sample Advertisement for Private Insurance
 - TM-17: Evaluation Form for Medicare Supplement Policies
 - TM-18: Evaluation Form for Medicare Supplement Policies (cont)
 - TM-19: Evaluation Form for Hospital Indemnity Policies
 - TM-20: Evaluation Form for Nursing Home Policies

REFERENCES:

1. Guide to Health Insurance for People with Medicare. U. S. Department of Health and Human Services and Health Care Financing Administration, HCFA-02110, January, 1981.

TEST QUESTIONS

Do You Need Private Health Insurance To Supplement Medicare?

Multiple Choice:

1. Medicare Supplement Policies
 - a. rarely cover the difference between "reasonable charges" and actual charges
 - b. do not pay deductibles and co-payments
 - c. do not provide extensions of hospital day limits under Medicare
2. Catastrophic or Major Medical Expense Plans
 - a. are readily available to people over 65
 - b. do not have deductibles
 - c. may be a good buy for those who feel that their greatest insurance priority should be protection from high cost of extended illness and catastrophically high medical bills

TRUE-FALSE

- T F 1. You can be "fully protected" by purchasing private health insurance to supplement Medicare.
- T F 2. Persons eligible for Medicaid should not purchase additional health insurance.
- T F 3. One of the best options for additional health insurance is the continuation or conversion of pre-65 coverage.
- T F 4. Hospital indemnity policies pay a specified daily amount regardless of any other health insurance coverage you have.
- T F 5. Most "nursing home" policies provide for your care in a nursing home when you can no longer care for yourself at home.
- T F 6. Limited Coverage--Specified Disease Policies are not considered good coverage, nor good buys.

Do You Need Private Health Insurance To Supplement Medicare?

Answer Sheet

Multiple Choice

1. a
2. c

True-False

1. F
2. T
3. T
4. T
5. F
6. T

HEALTH CARE AND SERVICES FOR CONSUMERS
DO YOU NEED PRIVATE HEALTH INSURANCE?
INFORMATION OUTLINE

I. Two Important Facts (Use TM-1).

Whether you need private health insurance in addition to your Medicare protection is a decision that only you can make. While Medicare covers a very substantial array of health care services, Medicare does not offer complete health insurance protection. Private health insurance, if it is carefully chosen, and if you can afford the additional expense, can help fill some of the gaps.

Most experts feel that if you can afford it, it is a good investment to buy the additional protection that private health insurance can provide, so long as you buy one of the better policies that offers you the kind of additional help you think you need most. But it is important for you not to be misled by the claims of a private insurer or a private insurance agent that you will be "fully" protected by buying private insurance!!

II. Amounts Not Paid by Medicare (Use TM-2).

For example, let's realistically look at the potential risk that is involved in actual dollar amounts if your coverage is Part A and Part B of Medicare. Actually you could spend as much as 60 days at one time in the hospital for only \$304.00 cost to you. If it is necessary to spend more than 60 days, the cost begins to increase because then you have to start paying \$76.00 per day for the days 61-90. If you used the entire 30 days, the cost would total \$2,280.00. Should your hospital stay continue beyond 90 days, you

would start using your 60 reserve days. At that point your cost would be \$152.00 a day making a total of \$9,120.00 for the 60 reserve days. It is true that if you spent 150 consecutive days in the hospital your total cost that would not be paid by Medicare would be \$11,704.00. However, while this dollar amount is very large, it is a small amount in dollars for 150 days in the hospital. Also, since the average stay in the hospital for persons 65 years and older is about 9-11 days, your chances of incurring more than the original \$304.00 deductible is rather remote.

ONE VERY IMPORTANT CAUTION - if you are eligible for Medicaid, which is a health care program administered by the State of Missouri, which helps pay medical expenses for low income people, DO NOT purchase private health insurance. The combination of Medicare and Medicaid pays almost all of your essential medical costs and those services that neither program covers are ALMOST NEVER COVERED by private health insurance policies.

III. Basic Types of Private Health Insurance (Use TM-3).

Private health insurers selling policies to add to your Medicare protection have designed a wide variety of policies to suit different needs and preferences. There are seven basic types of such insurance. They are:

1. Continuation or conversion of a policy you have when you reach 65.
2. Medicare supplement policies, which are specifically designed to pay some of the money amounts that Medicare does not pay for covered services.
3. Catastrophic or major medical expense policies, which are designed for high expense situations and do not begin paying until a large deductible is met.

4. Health Maintenance Organizations (HMOs), from which you purchase health care services directly for a fixed periodic advance payment.
5. Hospital indemnity policies, which pay cash amounts for each day of inpatient hospital services.
6. Nursing home policies, which pay cash amounts for each day of covered nursing home care. (Note: most policies provide protection only for skilled nursing as defined by Medicare).
7. Specified disease policies, which pay only when you need treatment for the disease insured against.

A discussion of each of these types of insurance is provided in greater detail in the following sections.

IV. Continuation or Conversion of Pre-65 Coverage (Use TM-4).

Many people, upon reaching age 65, already have private insurance coverage, either privately purchased, or, more frequently, in connection with their current employment. In these situations, most insurers will either permit continuation of coverage or conversion to a modified coverage taking your new Medicare coverage into account. If your prior insurance was partly funded by your employer, that premium sharing can sometimes continue in connection with your after-65 coverage.

While your decision to continue or convert existing coverage should be primarily based on how well such insurance will meet your individual needs, most experts rate this option as one of the best buys in additional health insurance protection for a number of reasons. First, you have uninterrupted coverage. Second, continued or converted coverage usually requires no medical history since that has already been established, so that there are no pre-existing condition exclusions. Third, if the prior policy was based on your employment, the continued or converted coverage is usually based on group premium rates, which are often lower than the premium rates

for individually purchased policies. And, of course, if your employer continues to share in the premium costs, your premium costs will be significantly reduced. You should ask your employer for a written outline of your post-retirement health insurance benefits.

One note of caution, however. If you have a spouse under 65 who was covered under the prior policy, make sure you are aware of what effect the continued or converted coverage will have on his or her insurance protection.

V. Medicare Supplement Policies (Use TM-5 and TM-6).

Medicare supplement policies primarily cover some or all of the deductible and co-payment money amounts Medicare does not pay. Sometimes they offer extensions of coverage for the services Medicare covers only up to certain maximums, such as the number of covered hospital days in a benefit period. The essential characteristic of a "Medicare Supplement" policy is that it usually only covers the same services that Medicare covers, but fills in some or all of the Medicare nonpayment gaps for those services.

Some Medicare supplement policies add additional coverages for services Medicare does not cover at all, such as drugs and medicines, but this is the exception rather than the rule. Very few Medicare supplement policies cover the difference between actual charges and "reasonable" charges for unassigned Medicare medical insurance claims for services by doctors and suppliers.

Most experts, however, feel that Medicare supplement policies offer excellent additional protection to Medicare beneficiaries if

they cover deductibles and co-payments under both the Medicare hospital and medical insurance and offer extensions of inpatient hospital day limits under Medicare, and particularly if they cover drugs and medicines to some degree.

VI. Catastrophic or Major Medical Expense (Use TM-7 and TM-8).

Some people may feel they can afford Medicare deductibles and co-payments or, because they have limited funds to spend on insurance premiums, may feel that they would rather insure against major expenses than against the smaller, periodic Medicare deductible and co-payment costs.

Catastrophic or major medical expense policies are designed for such preferences. Generally, a catastrophic or major medical expense policy will have a high initial deductible such as \$500 or \$1,000, before it begins paying. Thereafter, however, it will pay up to very large amounts, such as \$250,000, for the service it covers.

Very few catastrophic or major medical policies are available to people over 65 on an individual purchase basis. Most such coverage or policies are available only on the basis of membership in a group or association, or policies that are continuations or conversions of the pre-65 coverage. Where such policies are available, and of course, depending on the quality of the specific policy, catastrophic or major medical expense policies may be a good buy for those who feel that their greatest insurance priority is to protect themselves and their families from the high costs of an extended illness requiring expensive medical care.

VII. Health Maintenance Organizations (HMOs) (Use TM-9).

If there is a Health Maintenance Organization (HMO) in your area that is participating in Medicare, you may wish to consider this option. For people with Medicare, membership in an HMO offers additional protection similar to the purchase of a Medicare supplement policy.

An HMO is an organization that offers direct health services from its own doctors, hospitals, and other health delivery resources in return for a membership fee paid in advance, usually on a monthly basis. In effect, it both insures and provides health care services. It is, in short, a pre-paid health care system.

When you join a Medicare-participating HMO, you pay a membership premium to cover the Medicare deductible and co-payment costs, so that all Medicare-covered services are available to you without any additional cost. This means that, since all your Medicare covered services are prepaid under your HMO membership premium, you do not have to file any claims.

Many HMOs offer health care services in addition to those covered by Medicare, such as additional days of care or coverage of drugs and medicines. Some HMOs provide the additional services without increased premiums; others may charge a small added fee.

VIII. Limited Coverage - Hospital Indemnity (Use TM-10).

Hospital indemnity policies are a limited coverage type of policy in that they offer protection only for inpatient hospital care.

These policies usually pay a fixed amount on a per-day basis, for example, \$30 a day for each day of inpatient hospital occupancy.

Coverage may begin on the first day of hospitalization or on a later date. Some policies have a maximum number of days or a maximum payment amount. Some do not become effective immediately, but require a 3-month or more waiting period. Many exclude coverage for pre-existing conditions for one or two years or exclude certain pre-existing conditions permanently.

Generally, a hospital indemnity policy will pay the specified daily amount regardless of any other health insurance coverage you have. Many experts feel that, IF you are insured with a good general coverage, basic policy in addition to Medicare, a hospital indemnity policy can sometimes be valuable additional protection for those who can afford it. This is because it pays cash during a hospital stay that can help in meeting the additional personal and family expenses associated with a hospital stay. Other experts, however, note that the average hospital stay for Medicare beneficiaries is approximately 11 days. Further, they observe that the average beneficiary after reaching age 65 has three or four hospital admissions in his or her lifetime. They conclude, therefore, that hospital indemnity policies are not as good an insurance investment as more comprehensive supplementary policies would be.

IX. Limited Coverage - Nursing Home Coverage (Use TM-11, TM-12 and TM-13).

Some private health insurers sell what are advertised as "nursing home" policies. These policies generally pay a per-day amount for each day of care in a "nursing home." Before buying this kind of limited coverage policy it is extremely important that you fully understand exactly what is covered and what is not covered.

Nursing homes are classified into three broad types:

1. Skilled nursing facilities, primarily furnishing medical treatment and rehabilitative services.
2. Intermediate care facilities, primarily furnishing personal care and medical management services, but also having skilled nursing personnel and rehabilitative services available on an as-needed basis.
3. Residential or personal care facilities, primarily furnishing personal support services, such as help in eating, dressing, bathing, and taking medications.

Most "nursing home" policies on the market only cover medically necessary care in a skilled nursing facility. The great majority of elderly people who need nursing home care are in intermediate or personal care facilities, because their primary need is for assistance and support services resulting from their increasing inability to care for themselves in their own homes, even with the help of other family members. Many people buying "nursing home" policies, believing that they are protecting themselves against the day when they can no longer care for themselves at home, have been disappointed to discover that their policy does not cover such "nursing home" care.

X. Limited Coverage - Specified Disease Policies (Use TM-14).

A few insurers offer policies which are limited to treatment for a specific illness or a group of specific diseases. The most common type of policy in this area is cancer insurance.

Most experts caution purchasers to examine this kind of insurance very carefully.

First of all, Medicare covers much of the care needed by people with cancer and other diseases covered by a specified disease policy. Sometimes a specified disease policy has what is called a "coordination of benefits" clause. It does not pay, or pays far less

than expected, when another insurer, such as Medicare, is covering the same costs.

Secondly, many of these policies have very restrictive conditions regarding the type of treatment covered and in what types of facilities covered treatment can be reimbursed.

Thirdly, many of these policies have low maximum payments amounts which are quickly exhausted in the event of a long treatment period.

Do You Need Private Health Insurance?

TWO IMPORTANT FACTS

- Private health insurance can help you fill *some*, but not all of the Medicare gaps.
- If you are eligible for *Medicaid*, *do not* purchase private health insurance. The combination of Medicare and Medicaid pays almost all essential medical costs.

AMOUNTS NOT PAID BY MEDICARE

Days 1 through 60 . . .	The first \$304.00 not paid by Medicare.
Days 61 through 90. . .	\$76.00 every day, or a total of \$2,280.00
Days 91 through 150 . .	\$152.00 every day, or a total of \$9,120.00 is not paid by Medicare either.

GRAND TOTAL NOT PAID BY MEDICARE	<u><u>\$11,704.00</u></u>
----------------------------------	---------------------------

What Kinds of Private Health Insurance Can You Buy?

BASIC TYPES OF PRIVATE HEALTH INSURANCE

- Continuation or conversion of pre-65 coverage
- Medicare supplement policies
- Catastrophic or major medical expense
- Health maintenance organizations (HMOs)
- Limited Coverage Policies:
 - Hospital indemnity
 - Nursing home coverage
 - Specified disease coverage

What Kinds of Private Health Insurance Can You Buy?

CONTINUATION OR CONVERSION OF PRE-65 COVERAGE

- No waiting periods
- No pre-existing condition exclusions
- No medical data required
- Often includes spouse
- Employer often pays part of premium

What Kinds of Private Health Insurance Can You Buy?

MEDICARE SUPPLEMENT POLICIES

- Mainly cover only services *also* covered by Medicare; pay some or all deductibles and co-payments Medicare does not pay.
- The best Medicare supplement policies cover—Deductibles and co-payments under *both* hospital insurance and medical insurance.

Additional days of inpatient hospital and skilled nursing facility care .

CO-INSURANCE

THE AMOUNT OF EXPENSES THAT YOU MUST CONTINUE TO PAY AFTER THE DEDUCTIBLE HAS BEEN PAID. THE INSURANCE PROGRAM WILL PAY FOR THE REST OF THE ALLOWABLE EXPENSES.

What Kinds of Private Health Insurance Can You Buy?

CATASTROPHIC OR MAJOR MEDICAL EXPENSE

- Usually covers health care expenses after a large deductible is met (generally \$500–\$1,000).
- Excellent coverage for people who can afford Medicare deductibles and co-payments out-of-pocket, or who have a good basic insurance coverage.
- Not widely available after 65—usually continuation of pre-65 coverage.

DEDUCTIBLE

- THE AMOUNT OF THE EXPENSES THAT YOU MUST PAY BEFORE YOUR INSURANCE BENEFITS BECOME PAYABLE;
- MOST DEDUCTIBLES RANGE FROM \$100 - \$1,000.
(THE BIGGER THE DEDUCTIBLE THE LOWER THE PREMIUM)

What Kinds of Private Health Insurance Can You Buy?

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

(HMOs)

- Combined health insurance *and* health care delivery arrangement.
- In an HMO participating in Medicare—
 - You pay a membership fee.
 - All services covered by Medicare are furnished *through* the HMO.
 - Membership fee covers Medicare deductibles and coinsurance.
 - Services are pre-paid; no claims process.

What Kinds of Private Health Insurance Can You Buy?

LIMITED COVERAGE

Hospital Indemnity Policies

- Per day cash payments.
- Only pay for actual days in hospital.
- Often do not begin on first day of hospitalization.
- Often have maximum number of days or maximum payment amount for single hospitalization.
- Do not increase per day payments with inflation.
- May have pre-existing condition exclusions.

What Kinds of Private Health Insurance Can You Buy?

LIMITED COVERAGE

Nursing Home Coverage Policies

- Usually pay per-day amounts.
- Rarely cover care in other than skilled nursing facilities.
- Rarely cover care that is primarily *custodial*—care mainly to meet personal care needs such as bathing, feeding, dressing, taking medicine.
- Most U.S. nursing homes are not skilled nursing facilities.
- Most nursing home care needed by the elderly is custodial—i.e., personal care.

EXTENDED CARE FACILITY

A SKILLED NURSING HOME OR REHABILITATION CENTER
EQUIPPED TO PROVIDE FULL NURSING CARE WHICH HAS
A TRANSFER AGREEMENT WITH A HOSPITAL.

REST CARE OR CUSTODIAL CARE

CARE DESIGNED TO AID YOU IN PERFORMING THE
DAY-TO-DAY ACTIVITIES OF AN OTHERWISE HEALTHY
INDIVIDUAL, BUT DOES NOT REQUIRE A TRAINED
HEALTH CARE PROFESSIONAL.

What Kinds of Private Health Insurance Can You Buy?

LIMITED COVERAGE

Specified Disease Policies

- Usually cover single type of disease such as cancer or heart disease.
- Usually have maximum payment amounts for specific types of treatment.
- Often have restrictive conditions.

Here's How You Can Cope With The Latest Medicare Increases . . .

	WHAT MEDICARE WILL PAY AND WHAT YOU MUST PAY	WHAT THIS SUPPLEMENT PAYS YOU
DAYS 1-60 OF BENEFIT PERIOD*	MEDICARE PAYS all covered hospital expenses (room, board, operating room, etc.) except the \$304.00 Initial Medicare Deductible and for the first 3 pints of blood. YOU MUST PAY cash for the \$304.00 Initial Deductible and for the first 3 pints of blood.	WE PAY YOU the \$304.00 Initial Deductible.
DAYS 61-90 OF BENEFIT PERIOD	MEDICARE PAYS all but \$76.00 a day of the hospital charges. YOU MUST PAY the \$76.00 a day in cash totaling \$2,280.00 for the entire 30-day period of hospitalization.	WE PAY YOU the \$76.00 a day co-payment. We pay you this amount for every covered day you're hospitalized during this entire 30-day period, a total of \$2,280.00.
DAYS 91-150 OF BENEFIT PERIOD	MEDICARE COVERAGE ENDS unless you use your Lifetime Reserve (a back-up period of 60 days coverage you can use only once). YOU MUST PAY \$152.00 a day in cash while using up your Lifetime Reserve . . . totaling \$9,120.00 for the entire 60-day period.	WE PAY YOU the \$152.00 a day co-payment while you use up your Lifetime Reserve. We pay you this amount every covered day you're hospitalized during the entire 60-day period — totaling \$9,120.00.
DAYS 151 AND AFTER	MEDICARE PAYS NOTHING — your hospital benefits run out. YOU MUST PAY your entire hospital bill yourself . . . and that's cash out of your own pocket.	WE PAY YOU 90% of your eligible hospital charges up to the <u>lifetime maximum</u> of <u>365</u> days. We even pay for a private room if approved by Medicare.
SKILLED NURSING FACILITY CONFINEMENT DAYS	MEDICARE PAYS all but \$38.00 a day from the 21st to the 100th day of confinement in a Skilled Nursing Facility. YOU MUST PAY \$38.00 a day from your 21st to your 100th day of confinement . . . totaling \$3,040.00 for the entire period.	WE PAY YOU \$38.00 a day from the 21st to the 100th day of confinement <u>in</u> a Skilled Nursing Facility. Benefits are payable <u>when</u> a doctor requires that you be confined within 30 days of your release from a hospital stay of at least 3 days.
Benefits for Surgery, Physicians' Services and other Medical Expenses under Medicare Part B	MEDICARE PAYS 80% of the reasonable charges after you've satisfied the \$75.00 yearly Part B Medicare deductible. What Medicare defines as reasonable may be considerably less than you are charged; any additional charges are your responsibility. YOU MUST PAY the remaining amount that Medicare doesn't pay plus the \$75.00 yearly deductible.	NOTE: Does not Fill GAP in Part B! WE PAY YOU the <u>eligible</u> 20% Part B expenses that Medicare has determined as <u>reasonable</u> <u>after</u> the expenses exceed <u>\$200.00</u> per calendar year.

*Medicare Supplement Benefit Period begins with the first day you are hospitalized. It continues for as long as you're confined and for 60 days after you've been released from the hospital or Nursing Facility. You enter a new benefit period the next time you're hospitalized.

This Medicare Supplement is not connected with or endorsed by the U.S. Government or Federal Medicare Program. It pays the expenses shown above not covered by Federal Medicare.

SPECIAL ALERT TO MEDICARE CARDHOLDERS!

Now, more than ever, you need

SHOULDER-55

It pays 100% of these necessary medical expenses—NOT paid by Medicare

- 100% of your In-Hospital deductible.
- 100% of your In-Hospital co-payments.
- 100% of your reasonable hospital expenses for another full year after Medicare stops completely.
- 100% of your doctor, medical and surgical co-payments
Note → (that's the 20% that Medicare does NOT pay) after the first
\$200 of expenses each year. In or out of the hospital.

- Note - Does not provide coverage for doctors bills above "reasonable" charges!

EVALUATION FORM FOR
MEDICARE SUPPLEMENT POLICIES

NOT COVERED BY MEDICARE (1983 figures; subject to change in later years)	COVERED BY PROPOSED POLICY?		WHAT DOES PROPOSED POLICY	
	YES	NO	PAY?	COST?
\$304 for the first 60 days of in-patient hospital services in a benefit period (the inpatient hospital deductible)				
\$76 a day for the 61st to 90th day of inpatient hospital services in a benefit period				
\$152 a day for inpatient hospital services for each "lifetime reserve" day used (can be used up to a total of 60 days in your lifetime, whenever you need more than 90 days in a benefit period)				
Over 150 days of inpatient hospital services in a benefit period (over 90 days if you have used all your "lifetime reserve" days)				
\$38 a day for the 21st to 100th day in a benefit period for inpatient services in a skilled nursing facility				
Over 100 days of inpatient skilled nursing facility care in a benefit period				
Nursing home care in other than a skilled nursing facility				
Private room in a hospital or skilled nursing facility (except when medically necessary)				
Private duty nurses in a hospital or skilled nursing facility				
The first 3 pints of blood under either Medicare hospital or medical insurance				
The first \$75 of doctor bills and other medical services and supplies under Medicare medical insurance (the medical insurance annual deductible)				

EVALUATION FORM FOR
MEDICARE SUPPLEMENT POLICIES (CONT.)

NOT COVERED BY MEDICARE (1983 figures; subject to change in later years)	COVERED BY PROPOSED POLICY?		WHAT DOES PROPOSED POLICY	
	YES	NO	PAY?	COST?
After the first \$75 20% of "reasonable charges" for doctor bills and other bills for covered medical services and supplies under Medicare medical insurance				
Charges above the Medicare "rea- sonable charge" in non-assignment cases				
Drugs and medicines you buy yourself				
Eyeglasses (except after cataract surgery)				
Hearing aids				
Dental care				
Medical care outside the U. S.				

Are there any additional benefits the proposed policy pays? YES__NO__

If yes, describe. _____

a. Is there a pre-existing condition exclusion? YES__NO__

If yes, what conditions are excluded and for how long? _____

b. Is there a waiting period before policy pays benefits? YES__NO__

If yes, when does the policy begin paying benefits? _____

c. What is the cost? _____

d. What is the risk? (What are your chances of needing coverage
not provided by Medicare?) _____

EVALUATION FORM FOR
HOSPITAL INDEMNITY POLICIES

- a. What is the daily payment rate? \$_____ per day
- b. On what day of a hospital stay do payments begin?_____
- c. What is the maximum number of days the policy will pay?_____
- d. Is there a maximum payment provision? If yes, what is the maximum amount?_____
- e. Are there any excluded illnesses? If yes, describe.

- f. Are there any benefits in addition to the daily payment rate? If yes, describe.

- g. What is the cost?_____
- h. What is the risk? (Why do I need a cash payment or what would be the result if I didn't have a cash payment?)

EVALUATION FORM FOR NURSING HOME POLICIES

- a. Does the policy cover care in facilities other than skilled nursing facilities? YES NO

If yes, what other kinds of nursing homes?

Are these kinds of nursing homes available? _____

- b. Does the policy cover your stay in a skilled nursing facility or other nursing home when the care you need is primarily custodial care, that is, mainly personal care, such as help in feeding, dressing, getting in and out of bed, and taking medicine? YES NO

If yes, under what conditions and for how long will the policy pay for such care? Is this care available?

- c. Are there any excluded illnesses? If yes, describe.

- d. What is the cost?

- e. How great is my risk? (What are my chances for needing this kind of care? How could it be provided if I did not have this insurance?)

HEALTH CARE AND SERVICES FOR CONSUMERS

LESSON: Tips for Purchasing Private Health Insurance - If You Need It

CONCEPTS:

1. Once the decision has been made that additional private health insurance is needed to supplement Medicare, selecting a specific policy involves a careful comparison of costs and benefits.
2. Avoid being "sold" a health insurance policy by someone using "scare tactics" and/or high pressure selling techniques.
3. Contact the Missouri Division of Insurance, 515 E. High Street, Jefferson City, MO 65101. Ask for any new updated information for consumers on health insurance.

SUGGESTED ACTIVITIES:

1. Provide each participant with HO-2, which is a list of the 12 specific hints to be presented in this lesson.
2. Samples of health insurance promotional materials can be used to illustrate items such as pre-existing conditions, exclusions, waiting periods, etc.

INSTRUCTIONAL MATERIALS:

1. HO-1: Hints for Buying Private Health Insurance
2. Transparency Masters
 - TM-1: Hint #1
 - TM-2: Coordination of Benefits
 - TM-3: Hint #2
 - TM-4: Pre-Existing Conditions
 - TM-5: Hint #3
 - TM-6: Hint #4
 - TM-7: Hint #5

TM-8: Renewability
TM-9: Hint #6
TM-10: Hint #7
TM-11: Hint #8
TM-12: Hint #9
TM-13: Hint #10
TM-14: Hint #11
TM-15: Proof of Licensing
TM-16: Hint #12
TM-17: Free Look Provision

REFERENCES:

1. Guide to Health Insurance for People With Medicare.
U. S. Department of Health and Human Services and
Health Care Financing Administration, HCFA-02110,
January, 1981.
2. Solving the Health Insurance Puzzle for Senior Citizens.
State Department of Consumer Affairs, Jefferson City,
Missouri.
3. Jean Luttrell Weirich, Personal Financial Management.
Little, Brown and Company. Boston: 1983, pp. 450-468.
4. Information on Medicare and Health Insurance for Older
People. National Retired Teachers Association and
American Association of Retired Persons, Washington,
D. C., 1980.

NOTE: INFORMATION OUTLINE

Each of the transparencies in this lesson is self-explanatory with the background material that has been provided so far. Therefore, no other information outline is provided with this lesson.

TEST QUESTIONS

Tips for Purchasing Private Health Insurance

MULTIPLE CHOICE

1. If a policy is "renewable at company option"
 - a. you can always renew the policy
 - b. the company could cancel your individual policy for any reason at the end of the policy year or when premium comes due
 - c. the company has to renew the policy as long as you pay the premium
2. If a policy is "guaranteed renewable"
 - a. it must be renewed by the insurance company and cannot be cancelled by them
 - b. it cannot be cancelled if you don't pay your premiums
 - c. it cannot be cancelled by the policyholder
3. A "Free-Look" Provision means
 - a. the insurance company has ten days to reject you
 - b. the insurance agent can have free access to all your health records
 - c. you have ten days to review the policy and get a full refund on your premiums if you do not want it
4. If a policy has a "deductible", this means
 - a. there are some items not paid for
 - b. they deduct your premium before making any payments
 - c. you pay a certain amount before your insurance benefits become payable

TRUE-FALSE

- T F 1. Having more than one health insurance policy could mean that you are paying several premiums with no greater protection than a single good policy.
- T F 2. "Coordination of benefits" clauses prevent you from collecting from two different companies on the same cost.
- T F 3. A health insurance policy cannot refuse to pay costs for a condition that existed before you bought the policy.
- T F 4. If you purchase a new health insurance policy, your coverage must begin immediately.
- T F 5. Most health insurance policies pay unlimited amounts.

- T F 6. The Federal Government endorses some private insurance companies, but not all of them.
- T F 7. Less than 1% of the elderly exhaust their Medicare benefits.
- T F 8. Reliable and ethical insurance salespersons do not use "scare" tactics nor try to "high pressure" you into buying their policy.

Tips for Purchasing Private Health Insurance

Answer Sheet

Multiple Choice:

1. b
2. a
3. c
4. c

True-False

1. T
2. T
3. F
4. F
5. F
6. F
7. T
8. T

HINTS FOR BUYING PRIVATE HEALTH INSURANCE

1. DO NOT BUY MORE POLICIES THAN YOU NEED
2. CHECK FOR PRE-EXISTING CONDITION EXCLUSIONS AND WAITING PERIODS
3. BE CAREFUL ABOUT REPLACING EXISTING COVERAGE
4. BE AWARE OF MAXIMUM BENEFITS
5. CHECK YOUR RIGHT TO RENEW
6. BEWARE OF THE "GOVERNMENT LOOK"
7. TAKE YOUR TIME
8. BEWARE OF "SCARE TACTICS"
9. DO NOT WITHHOLD MEDICAL INFORMATION
10. GET A WRITTEN OUTLINE OF COVERAGE
11. DO NOT PAY CASH
12. MAKE SURE THERE IS A "FREE LOOK" PROVISION

Hints For Buying Private Health Insurance

SHOPPING HINT # 1

Do Not Buy More Policies Than You Need

- Many policies have a "coordination of benefits" clause—policy will not pay when another insurer pays or each insurer will pay part of the costs, not to exceed total actual cost.
- Duplicate coverage often means multiple premiums with no greater protection than a single good policy.

COORDINATION OF BENEFITS

COORDINATION OF BENEFITS PREVENTS DUPLICATION OR OVERLAPPING FOR THE SAME EXPENSE WHEN YOU OWN TWO OR MORE POLICIES. IT ALLOWS YOUR INSURANCE CARRIER TO BE AWARE OF ANY OTHER INSURANCE COVERAGE YOU MIGHT HAVE. THE TWO COMPANIES CAN THEN GET TOGETHER AND DETERMINE WHICH COMPANY HAS THE FIRST (PRIMARY) RESPONSIBILITY TO PAY AND WHICH COMPANY HAS THE SECONDARY RESPONSIBILITY AFTER THE BENEFITS FROM THE PRIMARY INSURER ARE EXHAUSTED.

Hints For Buying Private Health Insurance

SHOPPING HINT #2

Check For Pre-Existing Condition Exclusions and Waiting Periods

Be sure you know:

- When new policy begins paying.
- If any medical conditions are permanently excluded or not payable until a future date.
- You have this information in writing.

PRE-EXISTING CONDITIONS - COMPANY WILL NOT PAY COSTS FOR
ANY ILLNESS OR CONDITION WHICH
THE INSURED HAD BEFORE THE POLICY
WAS TAKEN OUT;

- USUALLY THE SHORTER THE PERIOD FOR PRE-EXISTING
CONDITIONS, THE BETTER;
- MAY NOT BE COVERED FOR 90 DAYS TO 6 MONTHS, EVEN
A YEAR OR LONGER;
- MISSOURI LAW REQUIRES NO LONGER THAN 24 MONTHS
UNLESS - 1) MENTIONED IN APPLICATION OR
2) SPECIFICALLY EXCLUDED FROM COVERAGE
- PRE-EXISTING CONDITIONS MUST HAVE MANIFESTED
ITSELF BEFORE THE EFFECTIVE DATE OF THE POLICY.

Hints For Buying Private Health Insurance

SHOPPING HINT #3

Be Careful About Replacing Existing Coverage

- Usually a waiting period.
- Your current medical condition may affect your new coverage.

—However, do not keep an inadequate policy just because you have had it a long time.

—If you do replace it, keep old policy until new one becomes effective.

Hints For Buying Private Health Insurance

SHOPPING HINT #4

Be Aware of Maximum Benefits

- Many policies have maximum payment amount under entire policy or for specific treatments. Some have maximum number of days or visits.
- Get the maximums in writing to see if they meet your needs.

Hints For Buying Private Health Insurance

SHOPPING HINT #5

Check Your Right To Renew

- Avoid policies "renewable at company option."
Company could cancel your *individual* policy for any reason at end of policy year or when premium comes due.

RENEWABILITY :

CONDITIONALLY RENEWABLE - CANNOT BE CANCELLED
OR RATES INCREASED UNLESS ALL MEMBERS OF A
CLASS OR A GROUP INSURED UNDER THE POLICY
HAVE THEIR RATES INCREASED;

PROTECTION: CANNOT BE CANCELLED BECAUSE OF
AN INDIVIDUAL CLAIM OR DISPUTE.

GUARANTEED RENEWABLE - MUST BE RENEWED BY
THE INSURANCE COMPANY AND CANNOT BE CAN-
CELLED BY THEM EXCEPT FOR NON-PAYMENT OF
PREMIUMS IS NOT GUARANTEED;

Hints For Buying Private Health Insurance

SHOPPING HINT #6

Beware of the "Government Look"

- Implied government affiliation or endorsement.
- Advertising literature designed to look "Governmental"—
 - Social Security envelope size.
 - Official-looking seal.
 - Correspondence begins with "Dear Medicare Member."

REMEMBER

- No private insurance company selling insurance to add to Medicare is affiliated with or endorsed by the Federal Government.

Hints For Buying Private Health Insurance

SHOPPING HINT #7

Take Your Time

- Don't be "high pressured."
- Beware of "short-term" enrollment periods or "last chance to enroll" statements. Ethical salespeople never "high-pressure" you.
- Buying insurance is an important decision. Take enough time to feel confident about your choice. Consult others if you can.

Hints For Buying Private Health Insurance

SHOPPING HINT #8

Beware of "Scare Tactics"

- Agent or advertising literature describes extreme situations to frighten purchaser.
 - Exaggerated expenses.
 - Exaggerated likelihood of illness.

REMEMBER

- Less than 1 percent of the elderly exhaust their Medicare hospital benefits.
- Only 4 percent of the elderly are in nursing homes.
- Few private health insurance policies cover services Medicare does not cover.

Hints For Buying Private Health Insurance

SHOPPING HINT #9

Do Not Withhold Medical Information

- Withholding medical information on a policy application may lead to non-payment for a later claim.
- Never believe salespersons who say you don't have to furnish such information when the application requests it or say they will fill in that information later.

Hints For Buying Private Health Insurance

SHOPPING HINT #10

Get a Written Outline of Coverage

- Always ask for a written description of the policy you are considering buying—in simple language.
- A company selling a good policy will always provide a simplified description of what they are offering for sale.
- Read it carefully.

Hints For Buying Private Health Insurance

SHOPPING HINT #11

Do Not Pay Cash

- Always pay by check, money order, or bank draft made out to the insurance company—never to the agent or anyone else.
- Always write down the name and address of the agent or insurance company, so you can follow up if there is any delay in getting your policy.

PROOF OF LICENSING

INSURANCE AGENTS LICENSED BY THE DIVISION
OF INSURANCE AND MUST SHOW PROOF OF THEIR
NAME AND COMPANY THEY REPRESENT.

Hints For Buying Private Health Insurance

SHOPPING HINT #12

Make Sure There Is A "Free Look" Provision

- Most reputable insurance companies have at least a 10-day period after you receive your policy to look it over. During that period, if you decide you don't want it, you can return it for a full refund of your premium.
- Beware of any insurance policy that is on a "take it or leave it" basis and does not give you a grace period to change your mind.

FREE LOOK PROVISION - (IN MISSOURI) 10 DAYS TO REVIEW
THE POLICY. IF YOU DO NOT WANT
TO KEEP IT, SEND IT BACK TO AGENT
OR COMPANY WITHIN 10 DAYS OF
RECEIVING IT AND GET A REFUND OF
ALL PREMIUMS AND ANY OTHER CHARGES
YOU HAVE PAID.

HEALTH CARE AND SERVICES FOR CONSUMERS

LESSON: How to Choose a Doctor

CONCEPTS:

1. There are many reasons why elderly persons find it difficult to select a doctor.
2. A personal physician should be selected first.
3. General Practitioners, Internists and Family Physician Specialists are good choices for the personal physician.
4. The personal physician can recommend additional specialists if they are needed.
5. Selecting a doctor depends upon your needs and his qualifications.

SUGGESTED ACTIVITIES:

1. Ask the group to share their experiences, procedures and recommendations for choosing a doctor.
2. Provide each person with HO-1 - Questions of Concern in Choosing Your Doctor.
3. Review reference materials and information outline.

INSTRUCTIONAL MATERIALS:

1. HO-1: Questions of Concern in Choosing Your Doctor
2. Transparency Masters
 - TM-1: Why it is Difficult for the Older Person to Find a Doctor
 - TM-2: Reasons the Older Person Has Trouble Finding a Doctor
 - TM-3: Personal Physician
 - TM-4: General Practitioner
 - TM-5: Internist Physician

- TM-6: Osteopathic Physician
- TM-7: Specialty Doctors
- TM-8: Suggestions in Selecting a Key Physician or Hospital
- TM-9: Questions of Concern in Choosing Your Doctor
- TM-10: Additional Concerns for Evaluating Your Personal Physician

REFERENCES:

1. Editors of Consumer Reports. Guide to Consumer Services, Revised Edition. Little, Brown and Company, Boston: 1980, pp. 228-240.

TEST QUESTIONS

How to Choose a Doctor

MULTIPLE CHOICE

1. A doctor who takes care of your overall health needs himself is called
 - a. a surgeon
 - b. a pediatrician
 - c. a general practitioner
2. Good choices for a personal physician would be
 - a. a general practitioner, an internist, or a Family Physician Specialist
 - b. a specialty doctor
 - c. a chiropractor

TRUE-FALSE

- T F 1. Specialty physicians such as surgeons, obstetricians, and gynecologists must have adequate training in that specialty.
- T F 2. A specialty doctor must be board certified by passing specialty exams.
- T F 3. A doctor who has been elected to fellowship in the American Academy of Family Physicians would not have any better qualifications for being your personal physician than a general practitioner.

SHORT ANSWER

1. Explain what is meant by the term "personal physician"?
2. Suggest ways to obtain names of doctors to consider as your personal physician.

How to Choose a Doctor

Answer Sheet

Multiple Choice:

1. c
2. a

True-False:

1. T
2. T
3. F

Short Answer:

1. Personal physician - A family doctor who acts as an all-around medical advisor for the family or individual. He/she treats ailments personally and calls in help (specialists) for difficult problems.
2. See list of suggestions for finding a doctor.

HEALTH CARE AND SERVICES FOR CONSUMERS

HOW TO CHOOSE A DOCTOR

INFORMATION OUTLINE

I. Why it is Difficult for the Older Person to Find a Doctor (Use TM-1 and TM-2).

"Based on eight (8) years of practical experience as the Scott County, Missouri, Director, Retired Senior Volunteer Program (ACTION-R.S.V.P.) of daily interviewing and counseling citizens sixty years of age and older."--Ellie Knight

1. Low self-esteem: "I'm not important", or "I don't want to be a bother", or "the doctor is too busy with sick people".
2. Their "old" family doctor is no longer around and they are uncertain as to how to search out a new one.
3. Specialty medicine is too expensive for their low and fixed incomes.
4. Feeling the doctor will categorize their problems as "just old age".
5. Disorientation--problem has been gradually increasing and they don't realize that they have a medical problem.
6. Low-educational level--unaware of benefits available or of how to utilize them.
7. Lack of trust--doctor will not take time to understand that they are slower to understand due to lessened response time because of mental or physical problems.

Because of this rationale, an informed elderly population is a necessity to insure both their physical and mental good health.

II. Identifying Differences in Doctors (Use TM-3, TM-4, TM-5, TM-6, and TM-7).

Define personal physician = as a family doctor who acts as an all-around medical advisor for the family or individual. One who treats many ailments personally and who calls in help for difficult problems.

A primary medical care doctor or personal physician may be a General Practitioner - one who takes care of your overall health needs himself.

A primary medical care doctor or personal physician may also be an Internist Physician. An internist is a doctor with post-graduate training in the broad field of internal medicine or specialist in internal medicine. This includes all areas of medicine except - Surgical - Obstetrics - Pediatrics.

Because of this broad training Internists are usually well qualified to serve as personal physicians and family medical advisors. They can take care of most common disorders themselves, but refer patients to other specialists when necessary.

A primary medical care doctor or personal physician may be an Osteopathic Physician. The osteopath through diagnostic and therapeutic methods applied to the musculoskeletal system make osteopathic medicine a most comprehensive approach to health problems.

Doctors the personal physician or family medical advisor refer to are called Specialty Doctors. This does not mean the physician can only practice in his specialty field. It only means he has

adequate training in a specialty. Each specialty board is responsible for the training requirements or qualifications and administering the certifying examinations of that specialty.

A physician who passes the specialty exam becomes board-certified and is known as a diplomat on that board. The physician then may become a member of a "college" = an honorary group of doctors whose main concern is continuing medical education within the specialty. Once certain qualifications have been met, the physician may be elected to fellowship in the college. Some of these are: American College of Obstetrics and Gynecology (FACOG); American Academy of Pediatrics (FAAP); the American College of Physicians (FACP); or the American Academy of Family Physicians (AAFP); and the American College of Surgeons (FACS). These initials after MD indicate the physician is a fellow of that particular specialty. However, the initials PC signify no professional qualifications. It only stands for Professional Corporation as some states permit physicians to incorporate their practices.

A new specialty area in the practice of medicine is the specialty of generalists called family practice. They received board certification in 1970 and the American Board of Family Practice conducts certifying examinations.

Doctors continue their education at hospitals through workshops, seminars, conferences, and expanded knowledge through discussions and associations with their colleagues as well as through experience with patients.

The ideal personal doctor, therefore, may be the General Practitioner who neither performs major surgery nor practices

obstetrics, the Internist, a Family Practice specialist, or the Osteopathic doctor. Being on the staff of an accredited hospital, preferably one that is also a teaching hospital, is good recommendation. The fact that doctors are board-certified or board eligible internists or that they're certified in family practice or members of the American Academy of Family Physicians (AAFP) does not automatically ensure the highest quality of care. It does increase the odds in the patient's favor.

When you choose a personal physician, you choose more than just a practitioner. You also choose the hospital or hospitals that that particular doctor uses for patient care.

III. Suggestions for Selecting a Qualified Physician to Meet Your Needs (Use TM-8 and TM-9).

If you are selecting a key physician and you are moving to a new location, the simplest way to choose a doctor is to ask a physician whose judgment you trust to recommend one. The physicians may be acquainted with doctors in your new area or may be able to verify for you the qualifications of possible family doctors. Otherwise, after you have moved you may check with a friend or relative whose judgment you respect and who knows your likes and dislikes. This could be a valuable lead in your search for a personal doctor. Or, you might check with the nearest accredited hospital and ask for a list of internists and general practitioners who are on its staff as attending physicians.

If a medical school is situated near your new home town, a telephone inquiry may produce the names of internists or qualified family doctors on the faculty who practice in your community.

The County Medical Society will provide names of internists and general practitioners in your immediate vicinity. Also, a listing can be found in the yellow pages of the telephone directory if you have no other good source.

With a list of qualified candidates, you can make a telephone survey to find one who seems suitable.

You may want to start with those whose offices are close to where you live, for convenience as well as prompt care in an emergency.

Let the doctor know that you are selecting a personal physician. Do not hesitate to ask questions such as: fee for office calls, hospital affiliation, medical school and qualifications, attitude towards home calls. Office staffs that employ medical and physician assistants may free the doctor's time from routine tasks. Don't hesitate to ask questions about any other matters that concern you. Your key personal physician then can help you in selecting specialists as they are necessary.

You may check also to see if there is a nearby prepaid comprehensive medical service plan that could provide the services of a qualified internist or family doctor. This plan of health care is known as health maintenance organizations (HMO). These plans offer subscribers a variety of medical services for a fixed monthly fee paid in advance. Some consumers may find the HMO style of health care delivery more to their taste than treatment in the traditional fee-for-service care, and possibly more economical.

After you have chosen a personal physician, or if you already have a personal physician, there are some additional concerns that you should take into consideration in evaluating your doctor, such as: (TM-10)

1. Is he friendly and courteous, and do you feel comfortable with him as a person?
2. Does he spend sufficient time with you, or does he have an overload of patients?
3. Does he schedule appointments realistically, so that you do not spend hours in his waiting room?
4. Would he be willing to call in another doctor for consultation if you were not satisfied with his recommendations?
5. Is he careful in prescribing only what drugs you absolutely need, or does he write prescriptions indiscriminately?
6. Will he be available in an emergency situation? If not, would he provide an adequate substitute?

If the answers to these questions are unsatisfactory, it might be wise to look around for another doctor.

However, keep in mind that someone who changes doctors for trivial reasons rarely benefits from an endless search for the ideal doctor. The chronic doctor shopper may be a greater loser than the patient who can overlook one or two uncomfortable encounters with the office bureaucracy or an isolated brusque moment with the doctor.

SUGGESTIONS IN SELECTING A PERSONAL PHYSICIAN

1. REFERRAL BY PREVIOUS PHYSICIAN
2. REFERRAL BY FRIENDS OR RELATIVES
3. REFERRAL BY HOSPITAL
4. MEDICAL SCHOOL RECOMMENDATIONS
5. COUNTY MEDICAL SOCIETY
6. YELLOW PAGES
7. COMPREHENSIVE MEDICAL SERVICES PLAN

QUESTIONS OF CONCERN IN CHOOSING YOUR DOCTOR

1. WHAT ARE HIS QUALIFICATIONS? IS HE BOARD CERTIFIED OR BOARD ELIGIBLE?
2. WHAT ARE HIS FEES?
3. WITH WHAT HOSPITALS IS HE AFFILIATED?
4. HOW ARE X-RAYS AND LABORATORY TESTS HANDLED?
5. WHAT IS HIS ATTITUDE TOWARD HOUSE CALLS?
6. HOW ARE TELEPHONE INQUIRIES HANDLED?
7. HOW IS THE OFFICE STAFFED?
 - a. MEDICAL ASSISTANTS?
 - b. PHYSICIAN'S ASSISTANTS?
 - c. REGISTERED NURSES?
 - d. LABORATORY TECHNICIANS?
 - e. SOMEONE TO PROCESS INSURANCE FORMS?

ADDITIONAL CONCERNS FOR EVALUATING YOUR PERSONAL PHYSICIAN

1. IS HE FRIENDLY AND COURTEOUS, AND DO YOU FEEL COMFORTABLE WITH HIM AS A PERSON?
2. DOES HE SPEND SUFFICIENT TIME WITH YOU, OR DOES HE HAVE AN OVERLOAD OF PATIENTS?
3. DOES HE SCHEDULE APPOINTMENTS REALISTICALLY, SO THAT YOU DO NOT SPEND HOURS IN HIS WAITING ROOM?
4. WOULD HE BE WILLING TO CALL IN ANOTHER DOCTOR FOR CONSULTATION IF YOU WERE NOT SATISFIED WITH HIS RECOMMENDATIONS?
5. IS HE CAREFUL IN PRESCRIBING ONLY WHAT DRUGS YOU ABSOLUTELY NEED, OR DOES HE WRITE PRESCRIPTIONS INDISCRIMINATELY?
6. WILL HE BE AVAILABLE IN AN EMERGENCY SITUATION? IF NOT, WHO WOULD HE PROVIDE AS AN ADEQUATE SUBSTITUTE?

8

**WHY IT IS DIFFICULT
FOR THE
OLDER PERSON
TO FIND A DOCTOR**

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TM-1

REASONS THE OLDER PERSON HAS TROUBLE FINDING A DOCTOR:

1. LOW SELF-ESTEEM.
2. "OLD" FAMILY DOCTOR GONE - UNCERTAIN HOW TO ACQUIRE NEW ONE.
3. SPECIALITY MEDICINE TOO EXPENSIVE FOR LOW/FIXED INCOME.
4. FEELING DOCTORS CATEGORIZE PROBLEM(S) AS "JUST OLD AGE."
5. DISORIENTATION.
6. LOW-EDUCATIONAL LEVEL.
7. LACK OF TRUST.

TYPES OF DOCTORS

1. PERSONAL PHYSICIAN = ALL-AROUND MEDICAL ADVISOR
FOR FAMILY/INDIVIDUAL.

TYPES OF DOCTORS

2. GENERAL PRACTITIONER = TAKES CARE OF OVERALL
HEALTH NEEDS HIMSELF.

TYPES OF DOCTORS

3. INTERNIST PHYSICIAN = POSTGRADUATE TRAINING IN
BROAD FIELD OF INTERNAL
MEDICINE. ALL AREAS
EXCEPT: SURGICAL--OBSTETRICS--
PEDIATRICS.

TYPES OF DOCTORS

4. OSTEOPATHIC PHYSICIAN = DIAGNOSTIC AND THERAPEUTIC
METHODS APPLIED TO THE
MUSCULOSKELETAL SYSTEM.

TYPES OF DOCTORS

5. SPECIALITY DOCTORS = MAY PRACTICE AS GENERAL PRACTITIONER, BUT HAS ADDITIONAL TRAINING IN A PARTICULAR SPECIALITY, AND IS USUALLY BOARD-CERTIFIED BY A GROUP (COLLEGE) OF OTHER DOCTORS WHO ARE SPECIALISTS IN THAT PARTICULAR FIELD.

SUGGESTIONS IN SELECTING A KEY PHYSICIAN OR HOSPITAL:

- A. REFERRAL BY PREVIOUS PHYSICIAN
- B. REFERRAL BY FRIENDS OR RELATIVES
- C. HOSPITAL
- D. MEDICAL SCHOOL
- E. COUNTY MEDICAL SOCIETY
- F. YELLOW PAGES
- G. COMPREHENSIVE MEDICAL SERVICES PLAN

QUESTIONS OF CONCERN IN CHOOSING YOUR DOCTOR

1. What are his qualifications?
2. What are his fees?
3. With what hospitals is he affiliated?
4. How are X-Rays and other laboratory tests handled?
5. What is the attitude toward house calls?
6. How are telephone inquiries handled?
7. How is the office staffed?
 - A. Medical assistants?
 - B. Physician's assistants?
 - C. Registered nurses?
 - D. Laboratory technicians?
 - E. Someone to process insurance forms?

ADDITIONAL CONCERNS FOR EVALUATING YOUR PERSONAL PHYSICIAN

1. Is he friendly and courteous, and do you feel comfortable with him as a person?
2. Does he spend sufficient time with you, or does he have an overload of patients?
3. Does he schedule appointments realistically, so that you do not spend hours in his waiting room?
4. Would he be willing to call in another doctor for consultation if you were not satisfied with his recommendations?
5. Is he careful in prescribing only what drugs you absolutely need, or does he write prescriptions indiscriminately?
6. Will he be available in an emergency situation? If not, who would he provide as an adequate substitute?

HEALTH CARE AND SERVICES FOR CONSUMERS

LESSON: How to Choose a Hospital

CONCEPTS:

1. Accreditation by JCAH (Joint Commission on Accreditation of Hospitals) means that the hospital conforms to basic standards in its operation and in the delivery of care and services.
2. Hospitals differ in types of ownership.
3. "Teaching" hospitals are generally recognized for their quality.
4. The hospital's billing procedures may be an important factor to you.

SUGGESTED ACTIVITIES:

1. Research the hospitals in your community to find out whether or not they are JCAH accredited.
2. Research ownership of the hospitals and identify those that are community, non-profit owned, government owned and those that are proprietary commercial establishments.
3. Identify those hospitals that are "teaching" hospitals.
4. Ask students if the last hospital they were in (as a visitor or a patient) was JCAH accredited.
5. Provide copies of HO-1 for students to follow and to refer to when they have an occasion to choose a hospital.

INSTRUCTIONAL MATERIALS:

1. HO-1: Four Major Questions in Selecting a Hospital
2. Transparency Masters
 - TM-1: Major Questions in Selecting a Hospital
 - TM-2: Types of Hospitals - Voluntary, Nonprofit, Community
 - TM-3: Proprietary Hospitals
 - TM-4: Government-Supported Hospitals

REFERENCES:

1. Editors of Consumer Reports, Guide to Consumer Services, Revised Edition. Little, Brown and Company, Boston: 1980, pp. 241-252.
2. Don R. Leet and Joann Driggers. Economic Decisions for Consumers. Wadworth Publishing Co., Belmont, California: 1982, pp. 410-415.

TEST QUESTIONS

How to Choose a Hospital

MULTIPLE CHOICE

1. When a hospital is accredited by the Joint Commission on Accreditation of Hospitals
 - a. you are guaranteed that this is a first-rate hospital
 - b. the hospital has conformed to basic standards in its operation and in the delivery of care and services
 - c. it will be very expensive
2. Proprietary hospitals
 - a. are government supported
 - b. usually have strict provisions for inspection, control and evaluation
 - c. usually have less control over medical qualifications and activities of physicians
3. Voluntary-non-profit community hospitals
 - a. usually have strict provisions for inspection, control and evaluation
 - b. lack necessary facilities for treating complicated illnesses
 - c. are never affiliated with a medical school

TRUE-FALSE

- T F 1. Two-thirds of all general hospitals in the United States are accredited by JCAH.
- T F 2. A teaching hospital is likely to provide a high quality medical service.
- T F 3. A privately owned or proprietary hospital generally is better equipped to handle complicated cases than a Voluntary non-profit community hospital.
- T F 4. A proprietary hospital would expect to make a profit where voluntary and government owned hospitals would not.
- T F 5. All hospitals have the same billing procedures.
- T F 6. Not all hospitals will provide an itemized statement of services when they are billing your insurance company.

How to Choose a Hospital

Answer Sheet

Multiple Choice:

1. b
2. c
3. a

True-False

1. T
2. T
3. F
4. T
5. F
6. T

HEALTH CARE AND SERVICES FOR CONSUMERS
HOW TO CHOOSE A HOSPITAL
INFORMATION OUTLINE

I. Four Questions to Ask in Making Your Selection (Use TM-1).

Hospitals differ sharply in quality of care and in scope of services. In selecting a hospital ask four questions:

1. Is the hospital accredited by the Joint Commission on Accreditation of Hospitals (JCAH)? Accreditation does not guarantee that a hospital is first-rate, but it does reduce the likelihood of substandard medical care and a hazardous physical plant.

If a hospital wants to be accredited it must conform to basic standards in its operation and in the delivery of care and services. Its conformity is evaluated by means of a detailed questionnaire and an on-site inspection by a JCAH survey team.

Interested consumers can participate in the evaluation by requesting a hearing before the on-site survey team.

A hospital given JCAH accreditation usually displays its certificate in the lobby. If you are uncertain whether a hospital is accredited you can find out by asking the hospital administrators or by writing to:

Office of Public Information of the JCAH
875 North Michigan Avenue
Chicago, IL 60611

Two-thirds of the 7,300 general hospitals in the United States are accredited.

2. Is it a teaching hospital? Does it have a formal program for training medical personnel? The higher the level of training,

the higher the level of medical services likely provided by the hospital. The best indicator of a good teaching program is the hospital's affiliation with a medical school. (You can find out if affiliated by writing to:)

Office of Public Affairs
American Hospital Association
840 North Lake Shore Drive
Chicago, IL 60611

Such hospitals are likely to have: qualified family doctors, full range of specialists, full-time staff physicians in charge of key departments.

If you do not have access to this, you can obtain similar benefits from a non-affiliated hospital approved for residency training in medicine or surgery.

The next best choice is a hospital that has a nursing school or training program such as laboratory or X-ray technician.

3. Who owns the hospital? Hospitals are in three categories. Hospitals within each category vary widely in quality. (TM-2)

Voluntary hospitals are nonprofit community institutions functioning under religious or other voluntary auspices. They generally offer good medical facilities and competent staff. In the best of them, there are strict provisions for inspection, evaluation and control of the medical activities of affiliated doctors.

Proprietary hospitals (TM-3) are commercial establishments. They intend to make a profit as well as keep the sick. The physical surroundings are often quite plush and the food may be tastier than in the Voluntary hospitals. Proprietary hospitals, on the whole,

exert less control over the medical qualifications and activities of their affiliated physicians.

Most proprietary hospitals treat relatively simple illnesses. Procedures such as traction, hernia operation, and routine obstetrical deliveries may be entirely adequate and the hospital be accredited. However, due to the lack of certain sophisticated equipment and services some of these hospitals may be poor places to treat complicated illnesses.

Government-supported hospitals. (TM-4) Range from the vary large to the quite small but all provide medical care for the indigent (though any sick person may be admitted). In general they offer good medical services. Those that are affiliated with medical schools, the facilities and staff may be superb. Government-sponsored hospitals accommodations may not be as comfortable as the Voluntary hospitals and may have to cut services when government budget cut-backs are initiated.

4. What billing procedures are used? Billing procedures should be checked out as to hospital acceptance of the individual's hospitalization plan, i.e. Blue Cross-Blue Shield, Company Major Medical Plan, Insurance Company Plan, or Medicare/Medicaid before admission. Does the hospital accept your membership card and bill directly to your company plan, or is it necessary for the individual to pay the bill and make their own application for reimbursement? Also, will the hospital provide an itemized statement of services if requested rather than a statement of total balance due for supplemental insurance coverage?

FOUR MAJOR QUESTIONS IN SELECTING A HOSPITAL

- I. IS THE HOSPITAL ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS (JCAH)?
- II. IS IT A TEACHING HOSPITAL?
- III. WHO "OWNS" THE HOSPITAL?
 1. VOLUNTARY, NONPROFIT, COMMUNITY HOSPITALS:
 - A. USUALLY OWNED AND OPERATED BY RELIGIOUS OR OTHER NON-PROFIT COMMUNITY ORGANIZATIONS
 - B. GOOD MEDICAL FACILITIES--COMPETENT STAFF
 - C. STRICT PROVISIONS FOR INSPECTION, CONTROL AND EVALUATION
 2. PROPRIETARY HOSPITALS:
 - A. COMMERCIAL ESTABLISHMENTS--TO MAKE A PROFIT AS WELL AS CARE FOR THE SICK
 - B. SOMETIMES HAVE BETTER PHYSICAL SURROUNDINGS; TASTIER FOOD
 - C. LESS CONTROL OVER MEDICAL QUALIFICATIONS AND ACTIVITIES OF PHYSICIANS
 - D. MAY LACK NECESSARY FACILITIES FOR TREATING COMPLICATED ILLNESSES
 3. GOVERNMENT-SUPPORTED HOSPITALS:
 - A. RANGE FROM QUITE LARGE TO VERY SMALL
 - B. MAY BE AFFILIATED WITH MEDICAL SCHOOL
 - C. SERVICES/STAFF USUALLY DEPENDENT UPON GOVERNMENT BUDGET REQUIREMENTS
- IV. WHAT BILLING PROCEDURES ARE USED?

THREE MAJOR QUESTIONS IN SELECTING A HOSPITAL

1. IS THE HOSPITAL ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS (JCAH)?
2. IS IT A TEACHING HOSPITAL?
3. WHO "OWNS" THE HOSPITAL?
 - A. VOLUNTARY
 - B. PROPRIETARY
 - C. GOVERNMENT

TYPES OF HOSPITALS

I. VOLUNTARY, NONPROFIT, COMMUNITY HOSPITALS:

- A. USUALLY RELIGIOUS OR OTHER NONPROFIT
COMMUNITY ORGANIZATION
- B. GOOD MEDICAL FACILITIES - COMPETENT STAFF
- C. STRICT PROVISIONS FOR INSPECTION, CONTROL,
AND EVALUATION

TYPES OF HOSPITALS

2. PROPRIETARY HOSPITALS:

- A. COMMERCIAL ESTABLISHMENT - TO MAKE A
PROFIT AS WELL AS CARE FOR THE SICK
- B. USUALLY BETTER PHYSICAL SURROUNDINGS;
TASTIER FOODS
- C. LESS CONTROL OVER MEDICAL QUALIFICATIONS
AND ACTIVITIES OF PHYSICIANS

TYPES OF HOSPITALS

I. GOVERNMENT-SUPPORTED HOSPITALS:

- A. RANGE FROM QUITE LARGE TO VERY SMALL
- B. MAY BE AFFILIATED WITH MEDICAL SCHOOL
- C. SERVICES/STAFF USUALLY DEPENDENT UPON
GOVERNMENT BUDGET REQUIREMENTS

HEALTH CARE AND SERVICES FOR CONSUMERS

LESSON: How to Choose a Dentist

CONCEPTS:

1. Dental care is important to your general state of health, even when there are no teeth.
2. Many dentists specialize in various areas, just as medical doctors specialize.
3. Your dentist should be selected on the basis of his qualifications and your needs.
4. In Missouri, reduced-cost, full-service dentistry is available to eligible persons through the Missouri Dental Association's Community Access Referral for the Elderly (CARE) program.

SUGGESTED ACTIVITIES:

1. Identify the dentists in your area as to whether or not they are general practitioners or one of the specialists.
2. For free brochures to be distributed to elderly consumers on the CARE program, contact:

Missouri Dental Association
101 W. McCarty Street
Jefferson City, MO 65101
Call: 1-800-392-0705

3. Use HO-1, HO-2, and HO-3 to emphasize things to consider in choosing and evaluating your dentist.
4. Study reference materials and information outline thoroughly.

INSTRUCTIONAL MATERIALS:

1. Pamphlets from CARE
2. Handouts

HO-1: Dental Specializations

HO-2: Sources of Names of General Practitioner Dentists

HO-3: Give Your Dentist a Checkup

3. Transparency Masters

- TM-1: How to Judge a Dentist
- TM-2: Dental Problems
- TM-3: The General Practitioner Dentist
- TM-4: Specializations
- TM-5: Sources of Names
- TM-6: Give Your Dentist a Checkup - "Shopping Trip" Information
- TM-7: Give Your Dentist a Checkup - Evaluation of Services
- TM-8: A Reduced-Cost Dental Program for the Elderly
- TM-9: Dental Fees - 1981

REFERENCES:

1. "A Reduced-Cost Dental Program for the Elderly", CARE-Missouri Dental Association, 101 W. McCarty Street, Jefferson City, MO 65101.
2. Editors of Consumer Reports, Guide to Consumer Services, Revised Edition. Little, Brown and Company, Boston: 1980, pp. 204-227.

TEST QUESTIONS

How to Choose a Dentist

MULTIPLE CHOICE

1. A dentist who specializes in the treatment of diseases of the supporting tissues of the teeth is called a/an
 - a. Prosthodontist
 - b. Endodontist
 - c. Periodontist
 - d. Orthodontist
2. You would expect an oral and maxillofacial surgery dentist to specialize in
 - a. the treatment of diseases of the inner portion of the tooth--the nerve pulp
 - b. the surgical removal of teeth or surgery of jaw structure
 - c. the correction of poorly positioned teeth and of defects of the jaw
3. A good dentist
 - a. constantly replaces old fillings and crowns, cuts down old teeth and applies caps, and generally keeps finding more work to do
 - b. explains treatment alternatives and gives you a part in making the decision about your treatment
 - c. never X-rays your teeth

TRUE-FALSE

- T F 1. Symptoms of some dangerous diseases are often seen in the mouth.
- T F 2. Poor nutrition and poor health can result from misaligned or loose teeth.
- T F 3. Your personal dentist should be able to perform all your dental needs without referring you to a specialist.
- T F 4. Unlike medical doctors, dentists do not have to pass special examinations in their specialty area before they are permitted to limit their practice to that area.
- T F 5. General Practitioner dentists are logical choices for your personal or family dentist.

- T F 6. A good dentist is prevention oriented and works to save teeth.
- T F 7. A good dentist takes a full set of X-rays at least once a year.
- T F 8. A dentist cannot tell you what his fees will be until he has performed the work.
- T F 9. Extra personnel like hygienists and dental assistants are evidence that you will pay a high fee for inferior work.
- T F 10. The Missouri Dental Association provides a reduced cost dental program for older persons who qualify.

How to Choose a Dentist

Answer Sheet

Multiple Choice:

1. c
2. b
3. b

True-False:

1. T
2. T
3. F
4. F
5. T
6. T
7. F
8. F
9. F
10. T

HEALTH CARE AND SERVICES FOR CONSUMERS

HOW TO CHOOSE A DENTIST (TM-1)

INFORMATION OUTLINE

I. Reasons Why Persons Should Have a Dentist (Use TM-2).

Dental disease is widespread in the general population. About one-half of the population has no natural teeth, upper or lower, by age 65. According to a 1973 National Health Survey, more than 20 million Americans have never visited a dentist. Misaligned or loose teeth make proper chewing difficult and in turn affect digestion; poor nutrition and poor health can result. Regular dental care by a good dentist can prevent many of the tragic dental health statistics and may be instrumental in detecting some dangerous diseases such as leukemia, syphilis, tuberculosis and diabetes.

II. Types of Dentists (Use TM-3).

1. The General Practitioner makes up about 86 percent of all dentists. They are designated by DDS (Doctor of Dental Surgery), or as a DMD (Doctor of Dental Medicine). These two general practitioners degrees are awarded at the end of four years of schooling. Your personal dentist should probably be a good DDS or DMD who is prevention-oriented and works to save teeth and who will be willing to refer you to a specialist if you need one.

2. Specialists. The American Dental Association (ADA) recognizes several specialty areas. Five of the most common are: (TM-4)

Orthodontics - The correction of poorly positioned teeth
and of defects of the jaw

Periodontics - Treatment of diseases of the supporting tissues of the teeth

Endodontics - Treatment of diseases of the inner portion of the tooth--the nerve or pulp

Prosthodontics - preparation of dentures

Oral and Maxillofacial Surgery - Surgical removal of teeth, surgery of jaw structure.

In the State of Missouri, dentists have to pass a state-administered examination in their specialty area before they are permitted to announce that their practice is limited to that specialty.

III. To obtain names of General Practitioners from which to Choose a Dentist (Use TM-5).

1. If you are moving, ask your present dentist to recommend someone in that area.
2. Ask the nearest dental school for the names of faculty members who might be practicing in your area. (You can write the American Dental Association, 211 East Chicago Avenue, Chicago, Illinois, 60611 for the name of the nearest dental school to you).
3. Check the yellow pages of your local telephone directory for a listing of dentists.
4. If you know a good specialist or are presently using one, ask that specialist to refer you to a good general practitioner. Because specialists have problems referred to them, they will probably have a good idea of which general practitioners are prevention-oriented, who try to save teeth and who are doing quality work.
5. Hospitals or neighborhood health centers in your area that provide dental service may make a recommendation for you.
6. Local dental societies can give you a listing of dentists, but will not evaluate them.

IV. Selecting a Qualified Dentist to Meet Your Needs (Use TM-6).

When you have received a recommendation that you would like to consider, go on a "shopping trip" to the dentist's office to do

further evaluation. You probably will be able to obtain this information from office personnel, or just by observation. Don't hesitate to inform the dentist or his staff that you are in the process of selecting a dentist and that there is certain information that you would be interested in obtaining. The type of information that you should try to obtain at this time is:

1. Is he conveniently located?
2. What are his office hours?
3. How long do you have to wait for an appointment?
4. How does he provide care in an emergency?
5. Is the office clean, neat, well equipped, efficient?
6. Does he use auxilliary personnel like hygenists, dental assistants, and laboratory technicians?
7. What are his fees? Will he give a written estimate of fees before treatment and itemized bills after treatment?

V. Further Evaluation that Should be Made (Use TM-7).

Some of the most important evaluation of the dentist and the quality of his work may not be possible until you have actually used his services. At this time several questions should be carefully considered in deciding whether or not to continue with this dentist or to seek another one. These points of evaluation are:

1. Does he take a thorough medical and dental history? Some medical conditions may require the dentist to take special precautions. He should make an attempt to obtain past dental and X-ray records.

2. How thoroughly does he examine your teeth and entire oral cavity? A full set of X-rays probably does not need to be taken more often than every four or five years. A survey of decay with

two to four X-rays called "bitewings" may be used in the interim. If your dentist never X-rays your teeth, there is some question as to how well he may be diagnosing problems.

3. Does he keep you informed about the exact condition of your mouth and teeth? Does he explain the various treatment alternatives and give you a part in making the decision about which alternative should be followed?

4. Does he provide information on ways to prevent dental disease and teeth problems and make every effort to save teeth?

5. Does he use effective techniques to reduce pain? Local anesthetics and the use of high-speed drills, ultrasonic cleaning and electrosurgery for removing tissue should keep dental pain to a minimum.

6. Is there suddenly more work to be done in your mouth than your previous dentist could find? Be cautious about the dentist who constantly wants to replace old fillings, add gold fillings, replace crowns or cut down old teeth and apply caps. Consult another dentist who is not connected with your present dentist if you suspect that you are being overtreated.

VI. A Reduced-Cost Dental Program for the Elderly (Use TM-8).

The Missouri Dental Association has established a reduced-cost, full-service dentistry plan for eligible persons. The program is called CARE (Community Access Referral for the Elderly). Persons who are at least 60 years of age and older are eligible to participate in the CARE program providing their annual gross incomes are less than \$7,000 for a single person or less than \$9,500 for a married couple. In addition, they must not be eligible for dental care through any public aid program or dental insurance plan.

If you are eligible for the benefits of CARE all visits and treatments following the first office visit will be discounted by at least 25 percent. Not all dentists have elected to provide services under this program. Persons who are interested should contact:

CARE
Missouri Dental Association
101 W. McCarty Street
Jefferson City, MO 65101
Call Toll Free: 1-800-392-0705

They will determine eligibility and provide you with a list of participating dentists.

G E N E R A L P R A C T I T I O N E R D E N T I S T S

DDS = DOCTOR OF DENTAL SURGERY

DMD = DOCTOR OF DENTAL MEDICINE

S P E C I A L I Z A T I O N S

ORTHODONTICS = THE CORRECTION OF POORLY POSITIONED TEETH
AND OF ORAL DEFECTS.

PERIODONTICS = TREATMENT OF DISEASES OF THE SUPPORTING
TISSUES OF TEETH.

ENDODONTICS = TREATMENT OF DISEASES OF THE INNER PORTION OF THE
TOOTH--THE NERVE OR PULP.

PROSTHODONTICS = PREPARATION OF DENTURES.

ORAL AND MAXILLOFACIAL SURGERY = SURGICAL REMOVAL OF TEETH;
SURGERY OF JAW STRUCTURE.

SOURCES OF NAMES OF GENERAL PRACTITIONER DENTISTS

1. IF YOU ARE MOVING, ASK YOUR PRESENT DENTIST TO RECOMMEND SOMEONE IN THAT AREA.
2. ASK THE NEAREST DENTAL SCHOOL FOR THE NAMES OF FACULTY MEMBERS WHO MIGHT BE PRACTICING IN YOUR AREA. (YOU CAN WRITE THE AMERICAN DENTAL ASSOCIATION, 211 EAST CHICAGO AVENUE, CHICAGO, ILLINOIS, 60611 FOR THE NAME OF THE NEAREST DENTAL SCHOOL TO YOU)
3. CHECK THE YELLOW PAGES OF YOUR LOCAL TELEPHONE DIRECTORY FOR A LISTING OF DENTISTS.
4. IF YOU KNOW A GOOD SPECIALIST, OR ARE PRESENTLY USING ONE, ASK THAT SPECIALIST TO REFER YOU TO A GOOD GENERAL PRACTITIONER. BECAUSE SPECIALISTS HAVE PROBLEMS REFERRED TO THEM, THEY WILL PROBABLY HAVE A GOOD IDEA OF WHICH GENERAL PRACTITIONERS ARE PREVENTION-ORIENTED, WHO TRY TO SAVE TEETH AND WHO ARE DOING QUALITY WORK.
5. HOSPITALS OR NEIGHBORHOOD HEALTH CENTERS IN YOUR AREA THAT PROVIDE DENTAL SERVICES MAY MAKE A RECOMMENDATION FOR YOU.
6. LOCAL DENTAL SOCIETIES CAN GIVE YOU A LISTING OF DENTISTS, BUT WILL NOT EVALUATE THEM.

GIVE YOUR DENTIST A "CHECKUP"

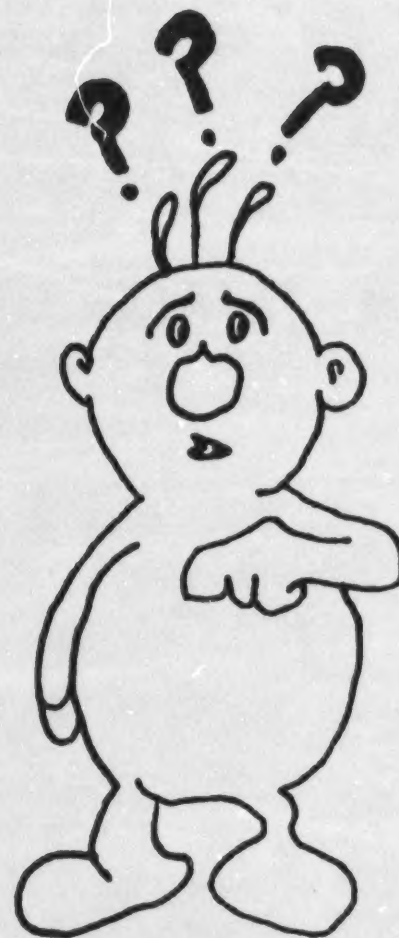
"Shopping Trip" Information

1. IS HE CONVENIENTLY LOCATED?
2. WHAT ARE HIS OFFICE HOURS?
3. HOW DOES HE PROVIDE CARE IN AN EMERGENCY?
4. HOW LONG DO YOU HAVE TO WAIT FOR AN APPOINTMENT?
5. IS THE OFFICE CLEAN, NEAT, WELL EQUIPPED, EFFICIENT?
6. DOES HE USE AUXILLIARY PERSONNEL LIKE HYGENISTS, DENTAL ASSISTANTS AND LABORATORY TECHNICIANS?
7. WHAT ARE HIS FEES? WILL HE GIVE A WRITTEN ESTIMATE OF FEES BEFORE TREATMENT AND ITEMIZED BILLS AFTER TREATMENT?

Evaluation of Services Performed

1. DOES HE TAKE A THOROUGH MEDICAL AND DENTAL HISTORY?
2. HOW THOROUGHLY DOES HE EXAMINE YOUR TEETH AND ENTIRE ORAL CAVITY?
3. DOES HE KEEP YOU INFORMED ABOUT THE EXACT CONDITION OF YOUR MOUTH AND TEETH?
4. DOES HE EXPLAIN VARIOUS TREATMENT ALTERNATIVES AND GIVE YOU A PART IN MAKING THE DECISION ABOUT WHICH ALTERNATIVE SHOULD BE FOLLOWED?
5. DOES HE PROVIDE INFORMATION ON WAYS TO PREVENT DENTAL DISEASE AND TEETH PROBLEMS? DOES HE MAKE EVERY EFFORT TO SAVE TEETH?
6. DOES HE USE EFFECTIVE TECHNIQUES TO REDUCE PAIN?
7. DOES HE "OVERTREAT" - CONSTANTLY FIND MORE AND MORE WORK THAT NEEDS TO BE DONE?

HOW TO
JUDGE A
DENTIST



TM-1

DENTAL PROBLEMS LIMIT THE KINDS OF FOOD THAT CAN BE EATEN. BECAUSE OF PAIN FROM IMPROPERLY FITTING DENTURES, OR GUM AND TOOTH PAINS, HARD, CRISP AND CHEWY FOODS ARE AVOIDED. INSTEAD OF EATING FRUITS, VEGETABLES, MEAT AND POULTRY, SOFT FOODS THAT NEED LITTLE OR NO CHEWING ARE CHOSEN. SO, IMPORTANT NUTRIENTS ARE MISSING IN THE DIET.



**THE
GENERAL PRACTITIONER DENTIST**

DDS - Doctor of Dental Surgery

DMA - Doctor of Dental Medicine

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TM-3

SPECIALIZATIONS

ORTHODONTICS = THE CORRECTION OF POORLY POSITIONED
TEETH AND OF ORAL DEFECTS.

PERIODONTICS = TREATMENT OF DISEASES OF THE SUPPORTING
TISSUES OF TEETH.

ENDODONTICS = TREATMENT OF DISEASES OF THE INNER
PORTION OF THE TOOTH--THE NERVE OR
PULP.

PROSTHODONTICS = PREPARATION OF DENTURES.

ORAL AND MAXILLOFACIAL SURGERY = SURGICAL REMOVAL OF
TEETH; SURGERY OF JAW
STRUCTURE.

SOURCES OF NAMES OF GENERAL PRACTITIONER DENTISTS

1. If you are moving, ask your present dentist to recommend someone in that area.
2. Dental School recommendations.
3. Yellow Pages of your local telephone directory.
4. Recommendation from a dental specialist you may know or may be using.
5. Recommendations from hospital or neighborhood health centers that provide dental services.
6. Local dental societies.

GIVE YOUR DENTIST A “CHECK-UP”

“Shopping Trip” Information

1. Is he conveniently located?
2. What are his office hours?
3. How does he provide care in an emergency?
4. How long do you have to wait for an appointment?
5. Is the office clean, neat, well equipped, efficient?
6. Does he use auxiliary personnel like hygienists, dental assistants and laboratory technicians?
7. What are his fees? Will he give a written estimate of fees before treatment and itemized bills after treatment?

GIVE YOUR DENTIST A “CHECK-UP”

Evaluation of Services Performed

1. Does he take a thorough medical and dental history?
2. How thoroughly does he examine your teeth and entire oral cavity?
3. Does he keep you informed about the exact condition of your mouth and teeth?
4. Does he explain various treatment alternatives and give you a part in making the decision about which alternative should be followed?
5. Does he provide information on ways to prevent dental disease and teeth problems? Does he make every effort to save teeth?
6. Does he use effective techniques to reduce pain?
7. Does he “overtreat” - constantly find more and more work that needs to be done?

**A reduced-cost
dental program
for the elderly . . .**



**. . . because Missouri dentists
CARE**

**Community Access Referral
for the Elderly
sponsored by
the Missouri Dental Association**

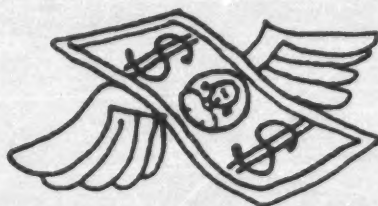
Call toll-free:

1-800-392-0705

9 a.m. to noon, Monday through Friday

DENTAL FEES--1981
AVERAGE RATES IN MISSOURI

INITIAL EXAM	\$ 15
COMPLETE X-RAY SERIES	25
CLEANING	15
SILVER FILLING (ONE SURFACE)	20
SILVER FILLING (TWO SURFACE)	25
GOLD INLAY (TWO SURFACE)	312
PORCELAIN CROWN	200
GOLD CROWN	300
ROOT CANAL THERAPY (ONE CANAL)	150
COMPLETE UPPER DENTURE	300
STANDARD REMOVABLE BRIDGE	300
PERMANENT BRIDGE (REPLACING ONE TOOTH)	600
SIMPLE EXTRACTION	15



HEALTH CARE AND SERVICES FOR CONSUMERS

LESSON: Facing Surgery? Get a Second Opinion

CONCEPTS:

1. Many physical conditions have alternative methods of treatment.
2. All surgery has benefits and risks which need to be considered.
3. Getting a second opinion may reveal more desirable alternatives with greater benefits and fewer risks.

SUGGESTED ACTIVITIES:

1. Ask participants if any of them were ever able to avoid having surgery by having a second opinion.
2. Write: SURGERY
HHS
WASHINGTON, D.C. 20201
for free copies of the brochure - Thinking of Having Surgery?
Think About Getting a Second Opinion.
3. Many elderly people do not get second opinions because of the cost. Be sure to emphasize that the cost of a second opinion is covered by Medicare, Medicaid and most private insurance policies.

INSTRUCTIONAL MATERIALS:

1. Thinking of Having Surgery? Think About Getting a Second Opinion. Pamphlet No. HCFA-02114, U. S. Department of Health and Human Services/Health Care Financing Administration.
2. Transparency Masters
TM-1: When Facing Surgery Get a Second Opinion
TM-2: Why Get a Second Opinion?
TM-3: Ask About
TM-4: What About the Cost of the Second Opinion?

REFERENCES:

1. Thinking of Having Surgery? Think About Getting a Second Opinion. Pamphlet No. HCFA-02114, U. S. Department of Health and Human Services/Health Care Financing Administration.
2. Don R. Leet and Joann Driggers. Economic Decisions for Consumers. Wadworth Publishing Co., Belmont, California: 1982, pp. 410-415.

TEST QUESTIONS

Facing Surgery - Get a Second Opinion

TRUE-FALSE

- T F 1. Medicine is an exact science in that there is consistent agreement among doctors about the best treatment for a specific illness.
- T F 2. Even minor surgery can be serious, particularly when a general anesthetic is used.
- T F 3. Medicare will not pay the expenses of a second opinion.
- T F 4. If your first opinion was given by a doctor who is a specialist, you would not need to consult an additional one for a second opinion.
- T F 5. If your family doctor and a specialist did not agree on your treatment, you should seek the opinion of another specialist.
- T F 6. Getting a second opinion when your doctor recommends surgery is advisable because the American Medical Association has disclosed the fact that many surgical procedures are used unnecessarily.

Facing Surgery - Get a Second Opinion

Answer Sheet

True-False:

- | | |
|----|---|
| 1. | F |
| 2. | T |
| 3. | F |
| 4. | F |
| 5. | T |
| 6. | T |

HEALTH CARE AND SERVICES FOR CONSUMERS

FACING SURGERY-GET A SECOND OPINION!

INFORMATION OUTLINE

INFORMATION TO BE PRESENTED: (Use TM-1, TM-2, and TM-3).

If the individual is facing surgery, why get a second opinion?

1. Surgery is a serious matter.
 2. Other satisfactory ways may exist to handle the problem.
 3. Doctor himself wants you to feel confident that surgery is best treatment for you.
 4. Medicine is not an exact science; doctors sometimes disagree.
- So that you can make better decisions about your health care, you should know the benefits, risks, and alternatives to surgery. When you have the opinion of two doctors, you should have enough information to make a choice about whether or not to have the surgery.

When do you get a second opinion? Whenever non-emergency surgery is recommended and when you do not know the alternatives you should Stop, Look, and Listen! Stop before having the surgery, Look for a specialist, Listen to a second opinion.

You can get a second opinion with or without the doctor who originally recommended surgery knowing about it.

If you tell the first doctor that you plan to have a second opinion and ask that your records be sent to the second doctor, you can avoid having to repeat tests that have already been done.

When you have your appointment with the second doctor, tell him or her the name of the surgical procedure and the diagnostic tests that were ordered by the first doctor. If the second doctor

disagrees with the first, and if you are still in doubt about what to do, you may want to discuss the options with yet a third doctor.

If the first and second doctors were both specialists, your family doctor is probably the person with whom you will want to talk it all over with.

If your family doctor was the first you consulted and the second was a specialist, you may wish to seek out another specialist.

There are several ways you can find specialists; you can ask your doctor to refer you to another doctor who is a specialist; you can find out where to locate a specialist near you by calling the following toll free number: 1-800-638-6833; if you are eligible for Medicaid, you can contact your local Welfare Office; if you are covered by Medicare, you can call your local Social Security Office listed under U. S. Government.

Medicare will pay for the second opinion at the same rate it pays for other office visits, diagnostic tests, laboratory procedures, and hospitalization. (TM-4).

Medical payments for second opinions vary from state to state. Check your local Welfare Office for rates applicable to the state you live in.

Many private insurance companies also provide coverage for second opinions. Check with your health insurance coverage company for details.

**WHEN FACING SURGERY
GET A SECOND OPINION !!**

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TM-1

WHY GET A SECOND OPINION?

ANSWER: THERE ARE DIFFERENT METHODS OF TREATING
THE SAME PROBLEM.

STOP--IF POSSIBLE BEFORE HAVING SURGERY!

LOOK--FOR ANOTHER SPECIALIST!

LISTEN--TO A SECOND OPINION!

FROM BOTH FIRST OPINION
AND SECOND OPINION DOCTORS ASK ABOUT:

1. THE BENEFITS OF THE SURGERY
2. THE RISK INVOLVED
3. OTHER TREATMENT ALTERNATIVES

WHAT ABOUT COST OF THE SECOND OPINION?

1. MEDICARE WILL PAY FOR THE SECOND OPINION AT THE SAME RATE IT PAYS FOR OTHER OFFICE VISITS, DIAGNOSTIC TESTS, LAB PROCEDURES, AND HOSPITALIZATION.
2. MEDICAID PAYS FOR SECOND OPINIONS IN MISSOURI.
3. SOME PRIVATE INSURANCE COMPANIES PAY FOR SECOND OPINIONS. CHECK WITH YOUR AGENT.
4. IF YOU HAVE TO PAY OUT OF YOUR POCKET, IT MAY BE WORTH THE COST IF IT PROVIDES A BETTER ALTERNATIVE THAN UNNECESSARY SURGERY.

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- Medicare and Private Health Insurance: A Training Text. U. S. Department of Health and Human Services, Health Care Financing Administration.
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- Weirich, Jean Luttrell, Personal Financial Management. Little, Brown, and Company. Boston: 1983, pp. 450-468.
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